EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION FILE NO. 1:23-CV-480

Planned Parenthood South Atlantic, et al.,

Plaintiffs,

vs.

JOSHUA STEIN, et al.,

Defendants,

and

PHILIP E. BERGER and TIMOTHY K. MOORE,

Intervenor-Defendants.

VIDEOTAPED DEPOSITION
OF
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TAKEN AT THE LAW OFFICES OF:
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09-01-2023
10:11 O'CLOCK A.M.

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I N D E X

STIPULATIONS 6
EXAMINATION
By Mr. Boyle 10, 167
By Ms. Swanson 160
ADJOURNMENT 170
REPORTER CERTIFICATE 171
WITNESS CERTIFICATION 172
WITNESS ADDENDUM 173

E X H I B I T S

Name	Offered By	Identified
(None marked)		

NOTE: Quoted material has been reproduced as read or quoted by the speaker.

STIPULATIONS

Pursuant to Notice and/or consent of the parties, the deposition hereon captioned was conducted at the time and location indicated and was conducted before Laura Baker, Notary Public in and for the County of Iredell, State of North Carolina at Large.

Notice and/or defect in Notice of time, place, purpose and method of taking the deposition was waived. Formalities with regard to sealing and filing the deposition were waived, and it is stipulated that the original transcript, upon being certified by the undersigned court reporter, shall be made available for use in accordance with the applicable rules as amended.

It is stipulated that objections to questions and motions to strike answers are reserved until the testimony, or any part thereof, is offered for evidence, except that objection to the form of any question shall be noted herein at the time of the taking of the testimony.

Reading and signing of the testimony was requested prior to the filing of same for use as permitted by applicable rule(s).

PROCEEDINGS

(10:11 o'clock a.m.)

THE VIDEOGRAPHER: On record. Today is September 1st, 2023, and the time is 10:11 a.m. I'm the videographer, Rachel Corcione, and the court reporter is Laura Baker.

This is the video deposition of Katherine Farris, MD, in the matter of Planned Parenthood South Atlantic, et al., versus Joshua Stein, et al., and Philip E. Berger and Timothy K. Moore.

Will counsel now introduce themselves for the video record, after which the court reporter will swear in the witness.

MS. SWANSON: Good morning. My name is Hannah Swanson of Planned Parenthood Federation of America. I represent Planned Parenthood South Atlantic, and I'm joined on the phone by my colleagues at Planned Parenthood Federation of America, Anjali Salvador, Kara Grandin, Dylan Cowit, Vanisha Kudumuri, Shealyn Massey. Vanisha and Shealyn are paralegals. And I'm also joined on the phone by Susanna Birdsong of Planned Parenthood South Atlantic.

MR. BOYLE: Good morning. My name is Ellis Boyle from the Wake County Bar. I represent the Legislative Leader Defendants, Speaker Moore and

Senator Berger. I believe I'm joined on this Zoom remotely by my co-counsel, Julia Payne, with the ADF.

MS. PAYNE: Yes, I am here.

MR. BOYLE: And I might just tick down the list so we don't overlap. Can we get Attorney General Stein's counsel next?

MS. NARASIMHAN: Morning. My name is Sripriya Narasimhan. I'm with the North Carolina Department of Justice, representing Attorney General Josh Stein.

MR. BOYLE: Next, the DAs other than Jim O'Neill?

MS. O'BRIEN: Good morning. Elizabeth O'Brien from the North Carolina Department of Justice, and I represent the district attorneys, except for District Attorney Jim O'Neill.

MR. BOYLE: Next, DA Jim O'Neill?

MR. WILLIAMS: My name is Kevin Williams with the Forsyth County Bar, and I represent District Attorney Jim O'Neill.

MR. BOYLE: Next. Secretary Kinsley?

MR. WOOD: Hi, good morning. This is Michael Wood with NCDOJ, and I'm counsel to Secretary Kody Kinsley of DHHS.

MR. BOYLE: Next. The Medical Boards?

MR. BULLERI: Good morning. This is Michael Bulleri with the North Carolina Department of Justice. I represent the North Carolina Medical Board and the North Carolina Board of Nursing.

MR. BOYLE: I think that's all of the groups of parties. If there are any other folks that are on, please identify yourself now. Thanks.

MS. AMIRI: Hi, everyone. Brigitte Amiri from the ACLU, and I represent the Plaintiff, Dr. Gray.

MS. MAFFETORE: Good morning, everyone. Jaclyn Maffetore of the ACLU North Carolina on behalf of all Plaintiffs.

MR. YOST: Good morning, everyone. Joshua Yost, General Counsel for Senator Phil Berger.

MR. HAYES: And Sam Hayes, General Counsel for North Carolina House Speaker Tim Moore.

MR. BOYLE: Going once? All right. Ready to begin?

THE COURT REPORTER: I need to swear in our witness.

MR. BOYLE: Yes.

The witness, KATHERINE A. FARRIS, MD, being first duly affirmed to state the truth, the whole truth, and nothing but the truth, testifies as follows:

EXAMINATION

BY MR. BOYLE:

MR. BOYLE: Good morning. We are on the record for the deposition of Dr. Farris. It's about 10:15 a.m. on September 1st, 2023. And we are located in the Ward and Smith Asheville office, with some counsel appearing remotely.

My name is Ellis Boyle, and I represent the Legislative Defendants in this case.

Q. (Mr. Boyle) Doctor, have you ever been deposed before?

A. No, I have not.

Q. Welcome. I'm sure you've heard this from your counsel, but I just want to go over a few ground rules. A deposition is a more formal conversation than we would have on -- you know, outside of a deposition or court setting, and so there's a few rules.

We like to keep our court reporter happy, because she is transcribing, writing down, all the words that we speak out loud during this deposition. So two big rules for that; number one, if I ask you a question, I ask that you please answer verbally out loud instead of nodding your head or saying, "uh-huh," which would be normal, and I would understand in a non-deposition context, but since we're having the court

reporter transcribe it, can you agree to do that, please?

A. I can.

Q. Great. And if we get down the path and you get a little off that, I may politely nudge you back. I'm not trying to be rude. Please don't be offended if I do that. Okay?

A. I understand.

Q. The second one is talking over each other. Again, to have a clean record for the court reporter, it's much better if I allow you to finish whatever you're saying and vice versa before the other one starts to talk again.

So I ask that you please try and be more cognizant of that than under normal conversation circumstances where you think you know where I'm going with my question, and you just start answering. Try to let me finish, even if I ramble, please.

A. I understand.

Q. Thank you. And then, finally, your lawyer may object during the course of this deposition. And unless there's an instruction not to answer for some privilege or similar-type reason, the expectation is that you'll respond to the question, even if there's an objection. Okay?

A. Yes.

Q. Very good. You work for Planned Parenthood South Atlantic, right?

A. That's correct.

Q. You're the medical director there?

A. My title is chief medical officer.

Q. Okay. Is there someone else who's the medical director?

A. I have an associate affiliate medical director who works under me.

Q. Okay. Are you the CEO or president or the highest officer in the operational process of the Planned Parenthood South Atlantic?

MS. SWANSON: Objection to form.

THE WITNESS: I am not the CEO. I'm the chief medical officer, and I am the highest ranking licensed person in the organization.

Q. (Mr. Boyle) Okay. Is there someone who has a title that works there day to day who is your boss, or are you sort of the person who runs the day-to-day operations?

A. I have a boss, yes. The CEO.

Q. Planned Parenthood -- and I'm going to call it "PPSA" -- or do you want to call it "P-P-S-A-T" or "PP-SAT"?

A. If we used an acronym, it would be PPSAT.

Q. Okay. I'll try to remember that. I wrote PPSA here, so please forgive me if I say it the wrong way. PPSAT charges money to perform induced abortions. Isn't that true?

A. Yes.

MS. SWANSON: Objection to form.

THE WITNESS: We do charge for the medical services we provide.

Q. (Mr. Boyle) And one of those medical services that PPSAT provides is induced abortions, right?

A. We do provide abortions.

Q. And you do charge for those induced abortions that you provide, right?

A. I do not charge, so I'm not directly involved with charging money.

Q. Would you say you're, what, second in command at PPSAT, or where do you fall on the org chart?

MS. SWANSON: Objection to form.

THE WITNESS: I am not second in command. I do report directly to the CEO, as do a number of other individuals.

Q. (Mr. Boyle) Okay. And you're aware, then, that PPSAT charges money to perform induced abortions

for patients who come to PPSAT seeking an induced abortion, right?

A. Yes. We do charge for our healthcare services.

Q. And I appreciate that. I just want to make sure I'm clear, because I asked about induced abortions. You do charge for induced abortions, including other healthcare?

MS. SWANSON: Objection to form.

THE WITNESS: We charge for all of the healthcare we provide, including induced abortions.

Q. (Mr. Boyle) Okay. Thank you. How much does PPSAT charge for each chemical abortion that it performs in North Carolina?

A. I believe that the cost for self-pay for a medication abortion is $625.

Q. Are there other prices that are charged other than for a self-paid patient who's obtaining a chemical abortion from PPSAT?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) In North Carolina, I should say.

A. In North Carolina, we also have insurance that we bill for abortion, and I believe that the cost for insurance is based on contracts, but I don't know the exact amount.

Q. Do you know if -- and as I understand, PPSAT operates in four different states, right?

A. That is correct.

Q. And you're the medical officer for PPSAT in all four states. Is that correct?

A. That is correct.

Q. When we're talking about PPSAT today, I'm primarily focused on what PPSAT does at the, what is it, six clinics here in North Carolina. So if there's any confusion, please let me know. But generally, when I'm talking about PPSAT, can we agree that we're talking about those six clinics in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: Just to clarify, we have more than six clinics in North Carolina. We only perform abortions at six of the clinics in North Carolina.

Q. (Mr. Boyle) Fair enough. How many clinics do you have in North Carolina?

A. Nine clinics in North Carolina.

Q. Okay. Which six clinics in North Carolina do you perform induced abortions at?

A. Planned Parenthood South Atlantic performs abortions at our Asheville, Charlotte, Winston-Salem, Fayetteville, Chapel Hill and Wilmington clinics in

North Carolina.

Q. So you do not perform them in Raleigh or Greensboro. Is that correct?

A. We do not perform abortions in Raleigh, Durham or Greensboro.

Q. Okay. So I'm primarily going to be asking about the six PPSAT clinics in North Carolina where you perform induced abortions. So if that gets confusing, please clarify and ask me to clarify. But that's my intent. Okay?

A. I understand.

Q. Very good. Do you know if PPSAT charges -- insurance companies that pay for medical or chemical abortions, do they charge more or less than they charge for the individual who's paying directly?

A. I believe that we have contracts with insurance companies in North Carolina that we charge for medication abortion, and I think that cost is higher if a patient is using insurance to pay for their abortion healthcare.

Q. Okay. Do you know how much PPSAT charges for each surgical abortion that it performs in North Carolina?

A. Procedural abortions are charged based on the gestational duration of the pregnancy. So I believe a

first trimester, so up through the 13th week of pregnancy, is $625. And then there are increases in cost based on gestational duration.

Q. What do those increases in cost based on gestational duration look like? What is the amounts?

A. I do not know those numbers off the top of my head.

Q. Do you know why there's an increase in cost-charge as the durational age goes up?

A. I was not part of making those decisions, so I don't know exactly why those costs change.

Q. Is the surgical procedure for an aspiration abortion at 14 weeks the same as a surgical procedure for an aspiration abortion at 16 weeks?

MS. SWANSON: Objection to form.

THE WITNESS: Every procedure is slightly different based on patient factors, but the difference between a 14-week abortion and a 16-week abortion is fairly minimal.

Q. (Mr. Boyle) Do you know if you charge -- if PPSAT charges more for an aspiration abortion at 14 weeks than they do for an aspiration abortion at 16 weeks in North Carolina?

A. No. I believe they do not charge more for 14 weeks than for 16 weeks.

Q. When does that difference, that increased cost, kick in then? Is it at week 17? Is it at week 18?

A. Can you please clarify your question?

Q. You just said that you don't believe that PPSAT North Carolina charges anything different for a 14-week aspiration abortion versus a 16-week aspiration abortion. Is that correct?

THE WITNESS: No.

MS. SWANSON: Objection to form.

THE WITNESS: That's not what I said. I said I do not believe that Planned Parenthood South Atlantic charges more for a 14-week abortion than for a 16-week abortion, which is what I understood you to be asking.

Q. (Mr. Boyle) Okay. That's not what I was asking. That's what I meant. So thank you for the clarification. I apologize for being confusing.

So when would that price difference kick in if it's not, say, 14 to 16 weeks? Is it at 17 weeks? Is it at 18 weeks?

A. I understand there to be a price difference when a patient hits 14 weeks that is higher than an abortion at 13 weeks. And I understand there to be incremental increases in abortion at some gestational

ages, but I don't know the date range.

Q. Okay. But you don't think it's 14 to 16 weeks? You think those would be charged the same?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know without looking at our fee service -- our fee -- I don't remember the name of the document, but there's a document that lists our fees.

Q. (Mr. Boyle) How much money does PPSAT make in one year for chemical abortions it performs in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) How much money does PPSAT make in a year for surgical abortions it performs in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) How much money does PPSAT make in a year for surgical abortions it performs in North Carolina for pregnant women in their 14th or later weeks gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) But you do know that when a

patient hits 14 weeks gestational age, PPSAT charges more for all of those surgical abortions 14 weeks and later than earlier time? So 13 weeks or less, correct?

A. I do know that the cost of an abortion at 14 weeks and later is higher than the cost prior to 14 weeks.

Q. How many chemical abortions does PPSAT perform in a year in North Carolina on patients who have a pregnancy that is not identified in the mother's uterus by using ultrasound?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know the exact number of abortions that Planned Parenthood provides -- pardon me, medication abortions that Planned Parenthood provides to patients with pregnancy of unknown location.

Q. (Mr. Boyle) Okay. You would agree that leading up until today, Planned Parenthood South Atlantic does perform chemical abortions on patients who have a pregnancy that is not identified in the uterus or located in the uterus by ultrasound. Is that correct?

A. Planned Parenthood does perform medication abortions on select patients who do not have a visible pregnancy within their uterus.

Q. And they charge money -- let me rephrase that.

Planned Parenthood South Atlantic charges money for those chemical abortions that it provides to patients who have an ultrasound, but you are not able to locate the pregnancy in their uterus, correct?

A. Planned Parenthood does charge for abortions on a patient with a pregnancy of unknown location. Yes.

Q. How much money do you think Planned Parenthood South Atlantic will lose in a year if it cannot perform surgical abortions in North Carolina for pregnant women in their 13th -- I'm sorry, 14th or later weeks gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I do not know.

Q. (Mr. Boyle) But you do know that currently, PPSAT is performing surgical abortions on women in their 14th week gestational age or later, and they are charging money for those abortions, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of -- I'm not sure if we have performed an abortion beyond the 12th week since the new law went into effect.

Q. (Mr. Boyle) Okay. Leading up to July 1st,

2023, you would agree that PPSAT North Carolina was performing surgical abortions on patients in their 13th week and later gestational age and charging money to perform those abortions, right?

A. Prior to July 1st, Planned Parenthood South Atlantic was performing procedural abortions beyond the 12th week of pregnancy and charging for those abortions, yes.

Q. And this law, this change in the law, has caused PPSAT to lose the income that it made from charging those patients for those abortions, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of what our income balance is since the change in the law.

Q. (Mr. Boyle) Well, you're aware that if you were performing those abortions before and charging money and getting paid for them, and now you're not, you've lost that money, right?

MS. SWANSON: Objection to form.

THE WITNESS: I am not aware of what money or what our income has been since the change in the law.

Q. (Mr. Boyle) Yes, I'm not asking about your general income or your general balance sheet. I'm saying, the simple fact is, if you were doing those

abortions and charging money for them before, and now you no longer are, you've lost that money that you made before, correct?

MS. SWANSON: Objection to form.

THE WITNESS: I think that would require me to speculate, because we've changed the services we provide since the law went into effect, and I can't speculate as to the exact impact that has had on our income.

Q. (Mr. Boyle) I'm not asking you to compare income. I'm just asking if you simply lose revenue from that potential source if you're no longer doing it.

MS. SWANSON: Objection to form.

THE WITNESS: I can state that we are not charging for abortions that we are not performing, and we are not performing abortions, routinely, beyond the 12th week of pregnancy since the law went into effect.

Q. (Mr. Boyle) You just said, "routinely." Are you performing them at all?

A. Legally, we can perform them. And I'm not personally aware of an abortion that has done -- that has been done past the 12th week that meets one of the exceptions.

Q. So as I understand your testimony, you're saying that it's possible that an abortion after the 12th week that meets one of the exceptions under the new law has been performed at a PPSAT clinic since July 1st leading up to today, September 1st, but you're just not aware of that.

A. Correct.

Q. Okay. I just want to clarify. If you were making money doing that type of abortion before July 1st when the law in effect, and now you're no longer doing it, you would agree that you've lost at least that money that you were able to make and charge for those abortions that you're not able to make and charge now, correct?

MS. SWANSON: Objection to form.

THE WITNESS: I would not characterize that I -- that PPSAT has lost money. I would characterize that PPSAT is not charging for procedures that we are not performing.

Q. (Mr. Boyle) PPSAT is a nonprofit. Is that correct?

A. Yes, that's correct.

Q. Does it provide any charity care to patients?

MS. SWANSON: Objection to form.

THE WITNESS: I am not deeply involved

in exactly how patients pay for abortions, so have some limited knowledge of how that works.

Q. (Mr. Boyle) Does it provide charity abortion care to patients?

MS. SWANSON: Objection to form.

THE WITNESS: I know that there are abortion funds that support patients who cannot afford to pay. So if they don't have insurance that covers the abortion or choose not to use insurance and they are paying the self-pay fee, some patients, it is my understanding, cannot afford to pay it, and I am aware that there are donation funds that support patients.

I'm not exactly sure when or how that money comes directly from Planned Parenthood versus other non-Planned Parenthood abortion funds.

Q. (Mr. Boyle) Fair enough. And when you say Planned Parenthood in that context of your last answer, are you talking about PPSAT, or are you talking about the parent organization, Planned Parenthood, sort of nationwide?

A. Thank you for clarifying. I was referring specifically to Planned Parenthood South Atlantic. I'm also not fully aware of Planned Parenthood Federation of America funds that may be supporting care.

Q. Okay. So it might happen, you're just not

aware of how and when.

A. Correct.

Q. Okay. And I don't need specifics, but you're paid to be the medical director on an annual basis for your work at PPSAT, right?

A. Yes, I am.

Q. Do you have any other jobs -- again, not looking for specifics. Do you have any other jobs where you work for money, you earn income outside of PPSAT, in the past five years, or do you dedicate your full workload and income earning to your job at PPSAT?

A. The only job I have is at PPSAT.

Q. Is that true for the past, say, five years?

A. Yes, that is true.

Q. Are you being paid for your testimony here today?

A. I'm not being paid differently for my testimony. I'm just working as the chief medical officer of Planned Parenthood South Atlantic.

Q. Take a water break.

Right. That -- and that's my question specifically, is, you know, sometimes expert witnesses are paid independently from their day job. Are you being paid as an expert witness beyond your normal salary that you derive working as the medical director

at PPSAT for your time testifying here today?

A. No, I'm not.

Q. So your role here today is as the chief medical director for one of the Plaintiffs in -- the parties in this case. Is that right?

A. My title is chief medical officer, and I am here speaking based on my knowledge as the chief medical officer of Planned Parenthood South Atlantic, who I understand to be a Plaintiff in this case.

Q. Sorry, when I do that weird thing, I'm thinking. I apologize.

Is part of your payment for your job at PPSAT derived from how PPSAT performs overall in any given year?

MS. SWANSON: Objection to form.

THE WITNESS: I do not have any change in compensation related to performance metrics.

Q. (Mr. Boyle) So you don't have incentive payments or bonuses or anything like that related to your job? Again, not asking for specific amounts, but any type of incentive payment.

A. I have received bonuses in the past, but never as an incentive related to -- when I think about bonuses in healthcare, often bonuses are applied for volume. I've never received a bonus from Planned

Parenthood South Atlantic based on the volume of care that I provided.

Q. Without going into details about numbers, why would you have gotten, or why did you get bonuses in the past from PPSAT?

A. I've received a bonus in the past when I took on additional job responsibilities. For example, serving as the interim -- I don't recall the exact title, but it's in my CV. The interim VP of patient services, I think. So it was a substantive change in my job description that they paid me a bonus for.

Q. Very small print on your CV.

MS. SWANSON: And, Ellis, if you're going to be referring to that, could we also have a copy to look at, please?

MR. BOYLE: Yeah, I was just looking to see if I remembered the name she was talking about. I don't know that I have a copy of her CV.

But I accept your explanation.

Q. (Mr. Boyle) So if PPSAT performs a certain metric of induced abortions in a year, are you paid more in that year for achieving that goal or metric?

MS. SWANSON: Objection to form.

THE WITNESS: No.

Q. (Mr. Boyle) But if the North Carolina law

that goes into effect that you're here testifying about in this case, if it goes into effect, your company, PPSAT, could lose money, because it will lose the ability to perform as many induced abortions. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: It's outside the scope of my job to speculate on the exact finances of the organization.

Q. (Mr. Boyle) Sure, but you're a very smart doctor, and common sense would dictate, I believe, that if PPSAT was performing induced abortions that it can no longer perform, and it loses the ability to derive that income from those induced abortions, PPSAT could and probably would lose money from this new law. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: PPSAT could lose money, or we could provide different services which would make up for any change in income.

Q. (Mr. Boyle) Fair enough. Do you engage in fundraising for any Planned Parenthood or abortion group?

MS. SWANSON: Objection to form.

THE WITNESS: I'm not sure what you mean

by, "engage in fundraising."

Q. (Mr. Boyle) Do you raise money for Planned Parenthood?

A. I do not personally raise money for Planned Parenthood, but I have been present at events, fundraising events.

Q. Okay. Your medical specialty is in family medicine. Is that right?

A. Yes, it is.

Q. You're not an OB/GYN, are you?

A. I am a family physician, not an obstetrician/gynecologist.

Q. You said it better than me. I'm going to do terrible with it, but I'm going to call it an OB/GYN, if that's all right. I can say that without confusing myself. You have no residency or fellowship training in OB/GYN, do you?

A. That is not correct.

Q. Okay. What residency or fellowship training do you have in OB/GYN?

A. Family medicine encompasses obstetrics and gynecology in their routine residency training.

Q. Okay. So beyond the -- and as I understand it, family medicine is sort of a combination of pediatrics and internal medicine, so typically, it

would be outpatient care for children and adults in a family medicine practice. Is that a fair assessment of that?

MS. SWANSON: Objection to form.

THE WITNESS: That is not how I would characterize family medicine, no.

Q. (Mr. Boyle) How would you characterize it?

A. Family physicians are trained to care for pregnant people, trained to perform deliveries, to care for pediatrics, to care for adult medicine, to take care of geriatric medicine, which is later adult, to do end-of-life care and to care for patients both in the hospital and in the outpatient setting.

Q. Okay. As part of your family medicine residency -- well, and let me just clarify. You didn't get any fellowship training in OB/GYN, correct?

A. That is correct. I did not do an additional fellowship.

Q. Did you do a fellowship in family medicine?

A. No, I did not.

Q. Are you board certified?

A. I am board certified in family medicine.

Q. Are you board certified as an OB/GYN?

A. No, I am not.

Q. Are you board certified in advanced family

planning?

A. I'm not aware of a board certification in advanced family planning.

Q. You haven't had a fellowship in advanced family training -- I'm sorry, advanced family planning, have you?

A. I'm not aware of a fellowship in advanced family planning.

Q. Which, I guess, means you are not fellowship trained in that.

A. I do ---

Q. Yeah.

A. --- not have a fellowship training in that.

Q. In your residency for family practice, describe for me what your rotations were, related to OB/GYN practice.

A. In my residency, we performed rotations that were more highly focused on obstetrics and gynecology, where we performed obstetrics and gynecologic surgeries, deliveries, both vaginal deliveries and C-sections. And we also, throughout the entire course of our residency, had our own obstetrical patients that we would follow regardless of what rotation we were on.

Q. And where did you do that residency, again?

A. Just outside of Seattle, Washington, in

Renton.

Q. Now did, in your residency, you have any training or experience performing induced abortions?

A. Yes, I did receive training in abortion during my residency.

Q. Describe that training for me, please.

A. Can you clarify what you mean by describing the training?

Q. What did you learn about abortion during your residency in that hospital near Seattle?

MS. SWANSON: Objection to form.

THE WITNESS: My training in abortion was primarily outpatient. I don't recall whether I did any abortions in the hospital, but I was trained to perform induced abortion in an outpatient clinic.

Q. (Mr. Boyle) When you did your training, that was after the chemical abortion protocols had been approved, and they were available as an induced abortion option, weren't they?

A. I don't recall exactly when that was approved.

Q. Did you do any residency training about chemical abortion drugs -- and I'm going to say them wrong, but I'm going to try, mifeprexin (sic), misoprostol, when you were in your residency?

A. I don't recall the exact details of training or the exact timing of when that was approved, but I do recall receiving some training on mifepristone and misoprostol as they are used for abortion.

Q. Did you receive that training you're thinking of during your residency?

A. I received it, I believe, during the time of my residency, yes.

Q. How long was your residency?

A. My residency was three years, if you include internship.

Q. What years were that -- was that again?

A. I started residency in 2000 and completed it in 2003.

Q. And from your residency, you went to work at Planned Parenthood in Massachusetts. Is that correct?

A. That was one of the jobs I took after residency, yes.

Q. What was the other job?

A. It was a comprehensive family practice job.

Q. Where was that?

A. It was in Fitchburg, Massachusetts. Actually, the office was in -- I believe that my office was located in Westminster, Massachusetts, and the hospital that I admitted at was in Gardner,

Massachusetts.

Q. And that was Heywood -- practice in Heywood Hospital?

A. Heywood Hospital was the name of the hospital, yes.

Q. What did you learn in your residency about induced abortions using aspiration or D&E procedures?

A. I learned a great deal about abortion. I'm not sure if you want me to outline everything I learned about abortion in that time.

Q. Probably not everything, but just give me some basics, and if I feel the need to explore further, I will. But just basically, what did you learn about those two procedures?

A. That they are incredibly safe and an important aspect of comprehensive sexual and reproductive healthcare.

Q. Did you learn how to perform any other gynecological surgery procedures?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) During your residency? Sorry.

MS. SWANSON: Same objection.

THE WITNESS: I learned to perform other gynecologic procedures during my residency, yes.

Q. (Mr. Boyle) Surgical -- gynecological

surgical procedures?

MS. SWANSON: Objection to form.

THE WITNESS: I did learn to perform some gynecologic surgery, primarily first assisting on C-sections.

Q. (Mr. Boyle) Okay. Have you done any C-sections as the lead doctor performing the surgery?

A. I have not been the primary surgeon on a C-section, no.

Q. Have you assisted with any C-section surgeries since you left residency?

A. Yes.

Q. When was the last time you assisted in a C-section surgery after residency?

A. I don't know the exact date or time, but it was when I was practicing in Massachusetts.

Q. So when you were practicing in Massachusetts, which I believe was from 2004 to 2007 -- is that roughly correct? Maybe 2003 to 2007?

A. I believe it was 2003 to 2007, yes.

Q. So during that period of your career, how many C-section surgeries did you assist with?

A. I don't recall the number.

Q. Was it, like, two or 2,000? I mean, can you give me a range maybe?

A. It was a routine part of the care I provided. If I had any patient who needed a C-section, I would first assist on that C-section routinely.

Q. I still don't have a sense, though. I mean, was that something that happened once a week, once a year?

A. I don't know the exact range, but it was on average, I believe, once a month.

Q. Okay. So maybe 40 to 60 times you assisted in a C-section surgery during that three-to-four-year stint?

MS. SWANSON: Objection to form.

THE WITNESS: I can't recall the exact numbers.

Q. (Mr. Boyle) More than 25 times?

A. I believe it would have been more than 25, yes.

Q. And you haven't done any since 2007. Is that correct?

A. I have not assisted in a C-section since 2007.

Q. What other gynecological surgical procedures did you train on and learn how to do in your residency?

A. I did not learn to be the primary surgeon on any other gynecologic surgeries.

Q. Okay. Did you learn how to be the primary provider who would perform an aspiration abortion during your residency?

A. Yes, I did.

Q. Did you learn how to be the primary provider who would lead on a D&E abortion during your residency?

A. No, I did not.

Q. Do you perform D&E abortions?

A. Yes, I do.

Q. When did you learn how to do that?

A. I learned to do that as a provider at Planned Parenthood South Atlantic.

Q. Okay. And you arrived at PPSAT in 2007 when you left Massachusetts. Is that correct?

A. I didn't start at Planned Parenthood South Atlantic until 2009.

Q. What did you do in between?

A. I had a second baby.

Q. Okay. So when you went back to work after that, you went to work at PPSAT in 2009, and you've worked there ever since. Is that correct?

A. That is correct.

Q. Okay. So you never had any formal training in a pedantic or academic setting about how to perform a D&E abortion. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know what you mean by, "pedantic academic setting."

Q. (Mr. Boyle) In school or residency.

A. I was not trained to perform D&E during a formal residency program.

Q. Who taught you how to do it at PPSAT?

MS. SWANSON: Objection, to the extent this calls for the name of a physician. This is something that ---

Q. (Mr. Boyle) Just give me something general. I don't need to know the name. That's fine.

A. More experienced providers at PPSAT who had extensive experience in D&E.

Q. As a family practice physician, you have experience providing prenatal care, don't you?

A. Yes, I do.

Q. And I think we've established, you've delivered babies in your practice, right?

A. Yes, I have.

Q. Do you still deliver babies currently in your practice?

A. I do not still perform deliveries, no.

Q. When was the last time that you delivered a baby, to rough recollection?

A. It would have been in probably 2007, before I left my practice there.

Q. Okay. So -- and I don't want to mischaracterize, but it sounds to me like -- since you left Massachusetts and stopped having whatever your privileges were at Heywood Hospital, have you not engaged in helping a mother deliver a baby since that time?

A. I have not performed deliveries since I left Massachusetts in 2007.

Q. Does any of your practice at PPSAT, since you've been there, involve prenatal care and providing care to mothers who intend to give birth to their children?

A. We do not provide comprehensive prenatal care. We do provide some general guidance for people who are attempting to become pregnant. And for people who have found they are pregnant and are wishing to continue their pregnancy, we provide primarily referrals to obstetricians for them to receive that prenatal care.

Q. And I'm -- and that makes sense to me. I'm just trying to see if I understand it completely.

So at PPSAT, if a patient comes in who tests positive as pregnant, and they want to continue the

pregnancy, you evaluate them sort of as an initial evaluation/confirmation and then you would refer them out to see an obstetrician for care through the pregnancy. And you all don't actually give that obstetrician care there and assist with the childbirth.

Do I understand that correctly?

MS. SWANSON: Objection to form.

THE WITNESS: I would clarify that when we have a patient who comes in and has a positive pregnancy test and chooses to continue their pregnancy, we provide them with resources to go see either a family physician who provides prenatal care or an obstetrician who provides prenatal care.

Q. (Mr. Boyle) Okay.

A. Or a certified nurse midwife who provides prenatal care.

Q. Does PPSAT provide -- and you may have said this; I apologize. I'm just trying to close it out.

Does PPSAT provide prenatal care for any patients up until the time of birth if they choose to continue a pregnancy?

A. No. PPSAT does not provide comprehensive prenatal care.

Q. When you worked at -- and is that true for the whole time you've worked at PPSAT, from 2009 up

until today?

A. Yes, it is.

Q. When you worked at Planned Parenthood in Massachusetts, did you -- were you involved with delivering any babies there?

A. I did not deliver any babies in my role at Planned Parenthood League of Massachusetts.

Q. Yeah. And I think you've said you did deliver babies in your role working at the hospital in the family practice, right?

A. That is correct.

Q. Okay. How many -- when you were working in Planned Parenthood Massachusetts, did you ever deliver a baby outside of a hospital up there?

A. In my role at Planned Parenthood League of Massachusetts?

Q. I'm sorry, I said that wrong.

During the time that you were working at both Planned Parenthood Massachusetts and at the Heywood Hospital, that 2003 to 2007 time frame, did you ever deliver a baby outside of a hospital when you were delivering babies up there?

A. No, I did not provide home births when I was -- or deliver any babies outside of a hospital when I was working in Massachusetts.

Q. Do you have admitting privileges to any hospital here in North Carolina?

A. Yes, I do.

Q. Which ones?

A. Novant Forsyth.

Q. Okay. Are you -- do you have privileges to perform surgical abortions at Novant Hospital in Forsyth?

A. No, I do not.

Q. Have you ever attempted to get hospital privileges to perform a surgical abortion in a hospital in North Carolina?

A. No, I have not.

Q. Are you eligible to obtain privileges to perform a surgical abortion in a hospital in North Carolina if you are not OB/GYN board certified?

A. I do not know how hospitals make their decision on eligibility for different privileges.

Q. You've just never tried to obtain that particular privilege at any hospital in North Carolina. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I have not attempted to obtain privileges to perform inpatient procedural abortions.

Q. (Mr. Boyle) Right. What do you have privileges for? I think you said, "admitting privileges." What does that mean? What are your admitting privileges at Novant Forsyth?

A. My admitting privileges at Novant Forsyth allow me to order certain types of tests, review medical records, go in and see patients who are in the hospital.

Q. Okay. Do you have privileges at any ambulatory -- outpatient ambulatory surgery center in North Carolina?

A. I don't actually know if ambulatory surgical centers have a privileging process. I do not work at any ambulatory surgical center in North Carolina.

Q. The only place that you perform surgical abortions in North Carolina since you started in 2009 is in a Planned Parenthood PPSAT clinic, right?

MS. SWANSON: Objection to form.

THE WITNESS: The only place that I have performed procedural abortions in North Carolina is at one of the Planned Parenthood South Atlantic clinics.

Q. (Mr. Boyle) Okay. Which one?

A. I have performed procedural abortions in all of the Planned Parenthood South Atlantic North Carolina locations that provide procedural abortion.

Q. Have you ever provided a surgical abortion in a hospital setting?

MS. SWANSON: Objection to form.

THE WITNESS: Yes, I believe that I have performed a procedural abortion in a hospital setting.

Q. (Mr. Boyle) Please describe what you recall about that.

A. I participated in abortion care during medical school, possibly during residency, but I don't actually recall.

Q. And anything that you would have been doing during medical school would have been more in an observational role, right? Not a hands-on performing a surgical procedure, but observing a doctor or a resident doing that, correct?

A. No, that is not correct.

Q. Were you actually holding the instruments and doing some of the procedures yourself in medical school?

A. Part of medical school includes hands-on training to perform procedures, yes.

Q. Did you hands-on perform any surgical abortions in a hospital setting when you were a medical student? If you don't remember, I don't blame you. I'm just ---

A. I ---

Q. --- clarifying.

A. --- believe I did, yes.

Q. Okay. So you perform D&E abortions now, but as I understand it, you've never received any specialized training or school or resident training on how to perform that procedure. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I performed D&Es, and I did receive formal training in performing D&Es. It was not in my capacity as a resident.

Q. (Mr. Boyle) When you say you received formal training, is there anything on your CV that would identify what formal training you received?

A. No, there is nothing on my CV.

Q. Is there any other specialized training that you may have received, since your residency completed, about how to perform surgical abortions?

A. I do not understand your question. Can you please rephrase that?

Q. Is there anything else on your CV that would suggest or show us that you had additional training or certification about how to perform a surgical abortion since your residency?

A. None of that training is reflected on my

resume.

Q. How many induced abortions have you performed in your career?

A. I do not know.

Q. Do you have any way to estimate?

A. Not without doing a great deal of math, no.

Q. How many would you say -- how many induced abortions, chemical and surgical, have you performed for patients within the past month?

A. I believe, in the past month, I've probably performed approximately 50 induced abortions.

Q. Okay. Is that typical -- is that a typical month for you in your practice?

A. Yes, I would say that it is.

Q. So if you typically do 50 a month, would you say that you typically do 600 a year, roughly?

MS. SWANSON: Objection to form.

THE WITNESS: The number of days that I have worked clinic has varied greatly throughout my career. So I would say that I have performed, on average, 50 a month for the past year, and that would probably be accurate.

Q. (Mr. Boyle) Okay. Were you doing more in the past or less than that 50 per month?

A. It ---

MS. SWANSON: Objection to form.

THE WITNESS: It has varied. There have been years where I worked more clinics per month on average, and there have been years where I worked fewer clinics per month on average.

Q. (Mr. Boyle) Would you say that, again, giving it a range, 500 to 700 a year, is a fair estimate based on the variability you've experienced over your career?

MS. SWANSON: Objection to form.

THE WITNESS: I am not good at doing math in my head, and so without actually calculating that, I'm not comfortable saying that.

Q. (Mr. Boyle) Okay. You've been performing induced abortions from 2000 to 2007, so seven years; and then 2009 to 2023, so another 13 and a half years. So for approximately 20 years, is that safe to say, that you've been performing induced abortions in your career?

A. I have been performing induced abortions for approximately 20 years, yes.

Q. Okay. Do you ever use a curette?

MS. SWANSON: Objection to form.

THE WITNESS: For what purpose?

Q. (Mr. Boyle) Do you know what a curette is?

A. Yes, I do.
Q. What is it?
A. A curette is a scraping tool that can be used for many different purposes.
Q. Okay. Have you ever used a curette?
A. Yes, I have used a curette.
Q. For what?
A. Primarily, for skin lesion removal.
Q. Have you ever used a curette -- well, are you performing skin lesion removal in your current practice, or would that have been back when you were working at the hospital in Massachusetts?
A. I do not currently perform.
Q. Do or have you used a curette in the past, say, 14 years, since you've been working at PPSAT, for any reason?
A. No, I have not used a curette since I have been working at PPSAT.
Q. Have you ever used a curette for any OB/GYN purpose?
A. I do not routinely use curettes for any OB/GYN purpose.
Q. Okay. So that's not something in your typical or scope of practice?
MS. SWANSON: Objection to form.

THE WITNESS: I would disagree that it's outside of my scope of practice and state that it's not a tool that I prefer to use.

Q. (Mr. Boyle) Fair enough. Not in your typical practice. Even if you could use it, you choose not to for whatever purpose you're treating a patient?

A. Yes. It's not a tool that I choose to use.

Q. Okay. When were you first contacted by Plaintiffs to be their expert witness, who offered opinions in this case?

A. I don't consider myself here as an expert witness. I -- based on the statements you made earlier about paid expert witnesses, I don't consider myself an expert witness as a paid person contacted.

Q. Okay. Would you consider yourself more of an employee of PPSAT who's here talking about PPSAT?

A. I consider myself an expert on the practices of PPSAT, and I consider myself an expert in the field of abortion care in my role at PPSAT.

Q. Okay. When were you first contacted by the Plaintiffs to give testimony of any kind in this case?

A. I don't remember.

Q. The lawsuit was filed, I believe, June 20th, roughly. Do you recall whether you were involved with the lawsuit before it was filed?

A. I would have participated in conversations prior to the filing of the lawsuit. Yes.

Q. You say you "would have." Did you, in fact?

A. I believe I did, yes.

Q. Okay. So -- and specific dates. You remember participating in conversations with lawyers on behalf of Planned Parenthood South Atlantic before the lawsuit was filed?

MS. SWANSON: Objection. I'm just going to direct you not to reveal the content of any communications with your lawyers.

Q. (Mr. Boyle) Absolutely not asking about the actual words. Just, did you actually speak to them?

A. I ---

Q. Before the lawsuit was filed. Sorry.

A. I did have conversations during the month of June ---

Q. Okay.

A. --- which would have been before the lawsuit was filed.

Q. And you filed a declaration with the original temporary restraining order that was filed sometime in later June. Do you recall that?

A. I recall filing a declaration. I don't recall the exact date of that declaration.

Q. You've seen what Dr. Boraas said -- and I apologize because I'm not very good with saying people's names -- Dr. Boraas said in her deposition on Tuesday, haven't you?

A. No, I have not.

Q. Have you seen what Dr. Wubbenhorst said in her deposition Wednesday?

A. No, I have not.

Q. So you're not aware of what the other three expert witnesses in this case have said in their depositions, are you?

A. No, I am not.

Q. You would agree that patient safety is always the most important consideration when you are treating a patient, wouldn't you?

MS. SWANSON: Objection to form.

THE WITNESS: I would agree that patient safety is one of the critical factors that should be considered for any procedure.

Q. (Mr. Boyle) Do you always choose to treat your patient in the safest way available?

MS. SWANSON: Objection to form.

THE WITNESS: I always consider patient safety when I am doing any procedure.

Q. (Mr. Boyle) And if you have two options

before you, one is safer than the other, do you always select the safer option when you're treating that patient?

MS. SWANSON: Objection to form.

THE WITNESS: I don't believe that there always is a clear differentiation between one option being safer absolutely than another.

Q. (Mr. Boyle) You said that's not always the case, but sometimes it's the case, isn't it?

A. There are times that there is a safer option that is clearly safer for the patient, and when that is the case, I do provide that option to the patient.

Q. What did you do to prepare yourself for this deposition today? Again, don't tell me about conversations you may have had with your lawyers.

A. I had conversations with my lawyers, and I reviewed a number of documents.

Q. Which documents?

A. I'm not sure if I can accurately list every single one. I reviewed both of my declarations. I reviewed -- and I apologize, I don't know legal terms, so I don't know the names of all of the documents.

But I believe that there were two intervener declarations, I think they were called. I reviewed both of those. I reviewed our -- again, I don't know

the term, our filing that we made. I reviewed SB20, the law in question, and I reviewed the amendments to the law ---

Q. HB190.

A. I believe ---

Q. Yeah.

A. --- it was HB190. And I reviewed some of the articles cited, both in my declaration and in the other physicians' declarations. And I reviewed documents that were presented to you.

Q. The ---

A. I'm not sure what they're called.

Q. --- PPSAT documents that were presented in discovery?

A. Yes, I believe so.

Q. Okay. A little bit of follow-up on that. Did you read Dr. Boraas's declaration and rebuttal?

A. Yes, I did.

Q. Okay. And it sounded like you said you read Dr. Wubbenhorst's declaration and Dr. Bane's declaration also.

A. Yes, I did.

Q. Okay. You mentioned some articles. Which articles did you review?

A. I don't remember them by name.

Q. You don't remember anything about them?
MS. SWANSON: Objection to form.
THE WITNESS: I didn't ---
Q. (Mr. Boyle) Can you describe ---
A. --- say that I don't remember anything ---
Q. Fair enough. That ---
A. --- about them, but I don't remember their names.
Q. Without necessarily remembering the formal name, do you recall what they were about?
A. They were about the safety of abortion and data on abortion.
Q. Can you give me a little more specifics so we can maybe ferret out which ones they were?
A. I don't think I can outline every single cited document I read, but I certainly reviewed the National Association of Science ---
Q. "The Academy" ---
A. National ---
Q. It's from 2018?
A. Thank you. The -- I'd have to look at the document to make sure I had the name correct.
Q. Yeah.
A. I reviewed an article, or a study, from Finland that was referenced by one of the other

physicians.

Q. That's the Niinimaki study; do you recall?

A. I do not recall without looking at the document.

Q. Okay.

A. I apologize. I've reviewed a number, probably four or five different -- and I don't recall the exact names ---

Q. Okay.

A. --- or their exact content.

Q. No, that's fine. Do you recall reading the Goldberg study from 2022 that was a retrospective review of, I believe, 2007 to 2012 or so, Planned Parenthood Massachusetts cases that had patients who were presenting with recent positive pregnancy tests, and they had ultrasound findings of pregnancy of unknown location. Do you recall reading that one?

A. I recall reviewing two articles on pregnancy of unknown location. I don't recall the level of detail that you just described, but if I were to look at the article, I could confirm whether I read it.

Q. Okay. Anything else?

A. Anything else?

Q. That you reviewed in preparation for this deposition other than what you've just told me?

A. I don't recall anything other than what I've just told you.

Q. Have you ever performed a surgical abortion on a patient who was pregnant with twins?

A. I have performed procedural abortions on patients who were pregnant with twins.

Q. How many times have you done that over the course of your career?

A. I do not know.

Q. Was it more than once? More than 100 times?

A. I would say it's definitely more than dozens.

Q. So 24? More than 25 times?

A. More than 25, I believe.

Q. Okay. That's fine.

And I asked you earlier about how many induced abortions you performed over the past month. I forgot to ask the sort of breakdown, chemical abortion versus surgical abortion. Can you give me a split? It doesn't have to be precise, but, you know, is it 50/50? Are you doing 75 percent chemical? What do you think that number looks like?

MS. SWANSON: Objection to form.

THE WITNESS: I have access that -- to that information if I were to look at our procedure logs, but I estimate that 60 percent of the abortions

that I performed in the last month were medication abortions and 40 percent were procedural abortions.

Q. (Mr. Boyle) Okay. If you look back over the course of your career, would you say that there's a higher percentage of those induced abortions that you've performed over the course of your career, a higher percentage of them skews to be medical abortion as opposed to surgical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: No. Over the course of my career, I would not say that the majority of the abortions I performed were medical over procedural.

Q. (Mr. Boyle) Okay. Can you give me an idea what you think the percentages would look like comparatively over the course of your career?

MS. SWANSON: Objection to form.

THE WITNESS: I can tell you that until I came to Planned Parenthood South Atlantic, I rarely performed medication abortions.

Q. (Mr. Boyle) Okay.

A. And since I came to Planned Parenthood South Atlantic, I would say that medication abortions accounted for anywhere from 40 to 60 percent of the abortions that I performed.

Q. Okay.

MS. SWANSON: Ellis, I'm just going to do a time check. I think we've been on the record for about an hour. So when you come to a good stopping point ---

MR. BOYLE: Let's take a break.

MS. SWANSON: --- if we could take a break?

MR. BOYLE: Off the record.

THE VIDEOGRAPHER: Off the record at 11:18.

(Brief recess: 11:18 a.m. to 11:29 a.m.)

THE VIDEOGRAPHER: On record, 11:29.

Q. (Mr. Boyle) Doctor, how do you know -- well, is it important to know if your patient is pregnant with twins before you perform a surgical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: If I know that a patient is pregnant with twins when I am performing a procedural abortion, I take extra steps to ensure that I have removed the tissue from the entire pregnancy.

Q. (Mr. Boyle) So you would agree it's important to know that beforehand, going into the procedure?

MS. SWANSON: Objection to form.

THE WITNESS: I would actually disagree.

I don't think it's necessarily important to know that beforehand.

Q. (Mr. Boyle) Is it important to know if a patient is pregnant with twins before you give that patient a medical -- yes, a chemical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: I do not find that being pregnant with twins changes the way we perform a medication abortion in the way that it can sometimes change a procedural abortion.

Q. (Mr. Boyle) What about with triplets? Would that change -- if a patient was pregnant with triplets, would that change the way you perform a chemical abortion?

A. No, it would not.

Q. Have you seen any studies about any increased risks or potential problems for patients who are pregnant with triplets or twins or quadruplets when you give them a chemical abortion?

A. I have not seen any studies on that.

Q. Excluding the lawyers who represent Plaintiffs in this case, have you spoken to anyone else about your involvement in this case?

A. I have spoken to other people from the context that they are aware that I was scheduling a

deposition, but only from the context of them being aware of how my time was being used.

Q. Just to clarify. So you haven't spoken about the substance of your opinions with anyone other than your lawyers. Is that correct?

A. That is correct.

Q. Okay. What is a uterine preforation?

MS. SWANSON: Objection to form.

THE WITNESS: I believe you are asking about a uterine perforation.

Q. (Mr. Boyle) What is it?

A. A uterine perforation is where usually an instrument, but sometimes a device, goes through the wall of the uterus, called the myometrium.

Q. What's on the other side of that wall?

MS. SWANSON: Objection to form.

THE WITNESS: The tissue within the retroperitoneum and abdomen.

Q. (Mr. Boyle) Are there any specific structures or tissues that typically surround the uterus and would be impacted if a surgical instrument or device punctured the uterine wall?

MS. SWANSON: Objection to form.

THE WITNESS: There are many different forms of tissue and organs. In particular, the bladder

is just anterior to the uterus in most patients, although there can be a space, and often is a space, between the uterus and the bladder; and the intestines can be in the space generally surrounding the uterus.

Q. (Mr. Boyle) Any other organs that would be immediately adjacent to the uterus, if there was a uterine perforation?

A. Those are the organs that are closest to the uterus.

Q. You would agree that uterine perforation is a known complication of a surgical abortion, wouldn't you?

A. Uterine perforation is an extremely rare but known complication of procedural abortion.

Q. Have you ever had a patient who you performed a surgical abortion on who suffered from a uterine perforation?

A. I have had a patient that I performed a procedural abortion on who had a uterine perforation.

Q. Did you have to transfer the patients, who you performed a surgical abortion on who suffered a uterine perforation from the Planned Parenthood clinic, to the hospital?

A. No, I did not.

Q. You -- are you aware that sometimes, if a

patient has a uterine perforation during a surgical abortion, it's required that they be transferred to a hospital for higher level of care?

MS. SWANSON: Objection to form.

THE WITNESS: I am aware that there are some cases of uterine perforation where the patient does need to be transferred to a hospital for additional care.

Q. (Mr. Boyle) Has that ever happened at PPSAT?

A. Yes, it has.

Q. Did you know before the surgical abortion was performed that those patients who suffered a uterine perforation would require transfer to the hospital based on that known complication?

MS. SWANSON: Objection to form.

THE WITNESS: I just want to clarify. Are you asking if I knew in advance that a patient would experience a uterine perforation and require transfer?

Q. (Mr. Boyle) That is what I'm asking.

A. No, it is not possible to know that in advance.

Q. Because you can't always know what complications will arise during a surgical procedure, can you?

A. It is true that with any procedure, you cannot always predict accurately what complications may arise.

Q. What is a cervical laceration?

A. A cervical laceration is a tear of the cervix.

Q. You agree that a cervical laceration is a known complication of surgical abortion, don't you?

A. I would agree that a cervical laceration is an extremely rare but known complication of procedural abortion.

Q. Have you ever had a patient, who you performed a surgical abortion on, who suffered from a cervical laceration?

A. I would say that I have had a patient who suffered from some bleeding associated with the instruments we use on the cervix, but I've never had a cervical laceration that required interventions such as suturing.

Q. Do some patients who suffer the known complication of surgical laceration during a surgical abortion require transfer to a hospital for a higher level of care?

MS. SWANSON: Objection to form.

THE WITNESS: I'm not aware of patients

needing to be transferred for cervical laceration.

Q. (Mr. Boyle) Are you aware of any patient from PPSAT who suffered a cervical laceration during a surgical abortion having to be transferred to a hospital to care for that known complication?

A. I do not recall any patient with a cervical laceration having to be transferred for that complication.

Q. Have you ever had a situation where you performed a surgical abortion on a patient and the patient suffered hemorrhaging such that you needed to transfer that patient to a hospital for higher level of care?

A. I have had a patient who hemorrhaged during a procedural abortion who I transferred to the hospital for care, yes.

Q. Is hemorrhage a known complication of surgical abortion?

A. Hemorrhage is an extremely rare and known complication of procedural abortion.

Q. Are you aware of other patients from PPSAT who have suffered hemorrhage during a surgical abortion that were transferred to a hospital for a higher level of care?

A. I am aware of patients who have suffered

hemorrhage during a procedural abortion who have been transferred to a hospital.

Q. Did you know, before the surgical abortion was performed, that those patients who suffered hemorrhage that required transfer to the hospital would have that complication during that surgical abortion?

A. No. You cannot know in advance what complication a patient may experience from any given procedure.

Q. Do you disclose all possible complications that can arise from an induced abortion to a woman who has tested pregnant, who has tested positive for pregnancy, who is your patient considering obtaining an induced abortion?

A. We disclose the most common and most concerning potential complications to patients as part of their informed consent.

Q. And tell me, what -- how many days is the waiting period now, under the new law, SB20 and HB190, for informed consent for a patient seeking an induced abortion before the induced abortion can actually occur?

MS. SWANSON: Objection to form.

THE WITNESS: My understanding of the current law is that it requires a 72-hour waiting

period from the time the State consent form is reviewed by the patient and signed and when the abortion takes place.

MR. BOYLE: I'm going to hand you a document that has Bates numbers that was produced in discovery.

MS. SWANSON: Thank you.

Q. (Mr. Boyle) It's Bates Numbers 31 through 50. If you don't mind, down at the bottom right-hand corner, do you see Bates and then numbers there?

A. I do see those numbers, yes.

Q. And the first page says Bates 31. Do you see that?

A. I do see that, yes.

Q. And then if you turn to the last page, please, you see Bates 50?

A. Yes, I do see that.

Q. Okay. So do you recognize this document?

A. Yes, I do.

Q. What is it?

A. This is our education and consent packet for procedural abortion.

Q. Can a patient die from complication of bleeding if there is a cervical laceration or a uterine perforation or hemorrhage?

MS. SWANSON: Objection to form.

THE WITNESS: I do not think a patient could die from a cervical laceration. Could a patient die from hemorrhage? They theoretically could die.

Q. (Mr. Boyle) Okay. How about uterine perforation, could a patient die from a uterine perforation if it's not treated?

A. If a complication was untreated, it's possible that a patient could experience severe complications that could lead to death.

Q. What surgical tools do you use in an aspiration abortion?

A. I use a number of tools, including a ring forceps, sterile gauze, dilators. I use a suction cannula that is attached to tubing and electronic vacuum aspirator or that is attached to a manual or handheld vacuum aspirator.

I use a tenaculum, which is an instrument used to hold the cervix, and I use a speculum. I sometimes use an ultrasound -- just thinking through my tray to see if there's anything I've left off. Those are the instruments I would routinely use for a suction abortion.

Q. Okay. What surgical tools do you use for a D&E abortion?

A. I would use the same tools for a D&E abortion and often use an additional type of forceps in addition to the ring forceps. There are different shapes and types of forceps, so I would often use a Bierer's forceps.

Q. Sorry, a what type?

A. Bierer's. I'm not sure how to pronounce it. I apologize.

Q. How do you spell it?

A. I'm not sure how to spell it. B-i-e-r-s (sic).

Q. Okay.

A. Maybe B-r-i-e-r-s (sic). I apologize. I don't recall the exact spelling.

Q. And what do -- what do the Bierer's forceps look like, if you can describe them?

A. So they are oval shaped. The best way to describe them is they look like a pair of scissors where they open and shut, but they don't cut at the end like a pair of scissors would. Instead, they have two flat plates at the end that are oval shaped and that close down around tissue.

Q. Like, they clamp on something and grab it?

A. A ---

MS. SWANSON: Objection to form.

THE WITNESS: A forceps will often close to be able to clamp, for example, on a gauze or on tissue.

Q. (Mr. Boyle) And what type of forceps do you use in the aspiration abortion, or the suction, abortion?

A. I routinely use a ring forceps in a suction abortion.

Q. And what's the difference between the ring forceps and the Bierer's forceps?

A. Well, I use the ring forceps for any abortion that I perform routinely. And the Bierer's, I use in a D&E. And the difference is the size.

Q. What's the difference in the size between them?

A. I don't know the exact measurements, but the Bierer's are slightly larger than the ring forceps.

Q. So the ring forceps also have the one end you have where you put your fingers to open and close the forceps, then you have a fulcrum, I guess, in the middle and then on the far end it's got two rings? Or are they ovals?

Are they -- are they loops that are sort of solid throughout, or do they have, like, just the outer rim is a loop? What's that like?

A. So a ring forceps has two open loops at the end that close down, and the other end has the handles where you would hold it.

Q. Okay.

A. And the Bierer's also has two open loops at the end, just the loops are oval in shape and slightly larger.

Q. Okay.

A. And the ring forceps, I would consider more circular.

Q. Okay. And the sort of clasping and the loops, if you will, they're not solid all the way through, they're just on the outer edge of the circle or the outer edge of the oval?

A. Correct. They are both hollow in the middle of the shape.

Q. What do you use the forceps, the ring forceps for, in the suction abortion?

A. Primarily, I use them for grasping gauze and wiping down the tissue within the vagina. That is the most common use. I also use them sometimes to grasp tissue that's coming out of the vagina. And very rarely, I introduce them inside of the cervix itself to grasp tissue.

Q. Typically, as I understand it, the major

difference between the suction abortion and the D&E is the use of the tongs beyond the cervix to grab tissue inside the uterus and pull it out. Is that -- am I understanding that correct?

That's the D&E versus the aspiration, you simply put the cannula in there, and it uses suction to suction out -- suck it out?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) Is that correct?

A. So when I am performing a suction abortion, I use suction throughout all -- as we are calling suction abortions or D&Cs, we use suction, and the suction removes most of the tissue of the pregnancy or all of the tissue of the pregnancy, most of the time.

When I am performing a D&E, I still use suction. That is a continuum where we use suction throughout a D&E as well. And with a D&E, I am more likely to use instruments. And later in pregnancy, I would say that I always use instruments to remove the pregnancy tissue later in -- with later D&Es.

Q. (Mr. Boyle) The pregnancy tissue that you remove in the later D&Es, what time frame, gestational age time frame, are you talking about?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) What weeks?

A. I consider a D&E any abortion 14 weeks or later.

Q. Do -- does PPSAT do D&E abortion at all six of the clinics in North Carolina where they perform induced abortions?

A. Since I consider a D&E abortion any abortion over 14 weeks, I believe we have performed abortions at approximately 14 weeks at all of our six North Carolina clinics.

Q. Because it looked like, from the chart that we received in discovery, that it's only Chapel Hill where the surgical abortions are occurring after, say, week 16, 17, 18. Is that correct, or are you doing those surgical abortions at all six clinics in North Carolina?

MS. SWANSON: Objection to form.

THE WITNESS: We do not routinely perform -- let me rephrase.

We, prior to this ban, were routinely performing abortions over 16 weeks at only two of our locations, both Chapel Hill and Asheville.

Q. (Mr. Boyle) Okay. On Page Bates 34 -- just let me know when you get there, please. Do you see that?

A. I see Page 34, yes.

Q. Top of the page says, "Information for Informed Consent In-Clinic Abortion," right?

A. Yes, that is what it says.

Q. Down, under "The risks of the in-clinic abortion are," I'm looking at "heavy bleeding." Do you see that?

A. I do see "heavy bleeding," yes.

Q. And it says, at the end of that, "Very rarely, you may have to go to the hospital for treatment." Do you see that?

A. Yes, I see that.

Q. The next one down, "Infection of the Uterus." It says, "Very rarely you may have to go to the hospital for treatment." Do you see that?

A. I do see that.

Q. You agree that post-twelve-week abortions can be performed in a hospital section -- setting, don't you? Let me say that again.

Post-twelve-week surgical abortions can be performed in a hospital setting. Is that correct?

A. I believe that they can be performed in some hospitals, but I am not sure that they are performed in most or all hospitals.

Q. And I understand you think they can be performed at the PPSAT clinics post twelve weeks for

the surgical abortion, right? That is a bad question.

You think that post-twelve-week surgical abortions can be performed in the PPSAT clinics, right?

A. I know that procedural abortions beyond twelve weeks can safely be performed in the PPSAT clinics.

Q. Do you also know that they can safely be performed in a hospital setting?

A. No, I don't know that they can safely be performed in any hospital setting.

Q. Okay. Are you worried that hospitals don't have the same resources and equipment and tools available to them that you have at your PPSAT clinic?

MS. SWANSON: Objection to form.

THE WITNESS: I don't work at a hospital, so can't speak exactly, but I do know that they have equipments and tools. I know they have some resources, but those resources might be different than PPSAT resources.

Q. (Mr. Boyle) But if you have a complication at PPSAT that PPSAT can't handle, you transfer that patient to a hospital, right?

MS. SWANSON: Objection to form.

THE WITNESS: In very rare instances, we have a complication where a patient does need to be

transferred to a hospital.

Q. (Mr. Boyle) So if you turn, please -- well, let me just ask you, on Page 34 there, and Page 35 and Page 36, that's all -- as I understand it, and you tell me if I'm wrong, that's all one three-page document about information for informed consent for in-clinic abortions. Is that correct?

A. You're asking about Bates 34, 35 and 36?

Q. Correct.

A. Correct. That is one PPSAT document.

Q. And it is one PPSAT document that PPSAT gives to patients who are seeking an in-clinic surgical abortion at a PPSAT facility. Is that correct?

A. This is a document that is given to and signed by patients who receive a procedural abortion at Planned Parenthood South Atlantic.

Q. Does the patient get a copy of this one three-page document?

A. It is our protocol to give the patient a copy of this document.

Q. When you look at Page 36, this looks like the signature page for the patient. Is that correct?

A. It is a signature page, yes.

Q. For the patient to sign when they're going to get a surgical abortion at a PPSAT facility. Is that

correct?

A. This is a signature page. We don't actually use paper forms for signature. We use an electronic health record, so we use an electronic version of this form, unless our electronic health system is down, and then we use the paper form. But the patient does sign an electronic version of this form, yes.

Q. Is the electronic version of this form exactly the same format as this paper copy here, this 34, 35 and 36?

MS. SWANSON: Objection to form.

THE WITNESS: I would -- I can't speak to the exact format, but it contains the same information. We use this form to create the electronic form.

Q. (Mr. Boyle) So you don't actually hand a patient this piece of paper, this three-page document. Is that what you're saying?

A. No, that is not what I'm saying. I do hand the patient this three-page document. We at Planned Parenthood hand the patient this document.

Q. Okay. So someone at -- at PPSAT hands the patient a three-page document that looks like Bates Number 34, 35 and 36, and that patient then has that hard copy paper document to take with them? Is that

correct?

A. It is correct that the patient receives a paper copy of this document before they leave the clinic -- or actually, when they are arriving and going through consent.

Q. Okay. Do the -- does the patient receive a signed copy of this document?

A. The patient does not routinely receive a copy of this form that they have signed, but they may receive a copy, if they would like, that can be printed from the EHR for them if they request it.

Q. So when the patient signs an electronic copy of this document, is the patient looking at a computer screen and having the opportunity to read all three pages before they sign, or do they have a paper copy? What's the method for that?

A. They have both. They have a paper copy in front of them, and they can see the electronic form as it is being filled out and they are signing it.

Q. And who goes over this document with the patient?

A. A trained staff member.

Q. What level of training does that staff member have?

MS. SWANSON: Objection to form.

THE WITNESS: They are -- they can have a variety of backgrounds of training, but they are specifically trained in the process of Planned Parenthood South Atlantic's informed consent.

Q. (Mr. Boyle) Is that person who undertakes informed consent with the patient, is that a nurse? Is that a PA? Is that an MD doctor? What level of training do they have?

A. It varies based on which aspect of informed consent you're referring to.

Q. Okay. How about this aspect with this three-page document? What level of PPSAT employee -- in terms of training for that employee, what level of employee is engaging with the patient to ensure informed consent is obtained?

A. It can be multiple levels. I've had nurses or physicians who participate in that. Routinely, it is not a licensed person who is going over the form. It is someone who is trained specifically in the process of consent who had -- goes over the form with the patient.

Q. Does the law speak to who has to interact with a patient, what level of training that person has, in order to ensure informed consent is indeed proper and legal?

MS. SWANSON: Objection to form.

THE WITNESS: My understanding of the law is that -- and I don't know the exact language, but that I believe it can be a nurse, physician assistant, advanced practice clinician or advanced practice nurse, such as nurse midwife, or an NP, or a physician who can perform -- or pardon me, who must perform the advanced consent mandated by the State using the State's 72-hour advanced consent forms for both procedural and medication abortion.

Q. (Mr. Boyle) Does this document we're talking about here, this three pages Bates Numbered 34, 35, 36, does that qualify as satisfying the State's required informed consent you just described?

MS. SWANSON: Objection to form.

THE WITNESS: No, this is done in addition to the State's mandated consent.

Q. (Mr. Boyle) Is -- and it may be in here, and I may just ask you to direct me. Does that mandated consent from the State exist in here in these documents?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) And you can take your time looking through the package if you'd like.

(Witness examines document)

A. This packet does not contain the State's consent form.

Q. So this packet that was given to us as PPSAT's informed consent documentation that they give to patients is missing the actual State-law-required informed consent. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: This packet does not contain the State consent. The State consent is performed by necessity and law 72 hours prior to the abortion. This consent is signed at the time of the abortion.

So we review and go over the state forms at the 72-hour consent and provide the patient with a copy of the form both at that time, and we provide them with another copy of that form at the time of their abortion. But because they are separate forms used at different times in the process, they're not part of the exact same packet.

Q. (Mr. Boyle) So you're saying there exists a separate informed consent document from the State that's not included here, but you know it exists and you've seen it and participated in those State-law-required informed consent conversations yourself with some patients. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: The State requires that we use State-created forms, so we access those State-created forms from the State and use them for the advanced consent.

Q. (Mr. Boyle) And you agree that form is not in this packet starting at Page 31, running to Page 50. Is that correct?

A. That form is not a part of this packet, correct.

Q. And as I understood you to just say, this packet that we're looking at, specifically Bates 34, 35, 36, that three-page document, is something that is discussed with the patient and signed at the time of the abortion, the surgical abortion. So the day of the surgical abortion. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: A copy of this paper packet is routinely provided to the patient at the time of their 72-hour consent for their review. We do not ---

Q. (Mr. Boyle) Okay.

A. Let me correct.

We review it and sign the actual forms that require signature in this packet at -- on the day of

the abortion, not at the 72-hour consent.

Q. Okay. And I think I understand it now. Let me just -- very slow. I apologize. I'm working through it.

Day one, patient comes in, decides, "I want to have a surgical abortion."

PPSAT says, "We will do that, but there is a 72-hour required waiting period for informed consent under State law. Here is that form," that we don't have a copy of. "Here's that form," which you go over with the patient, they sign, starting the clock.

And you also give them a copy of this three-page document, Bates Number 34, 35, and 36, but you don't have the patient sign it on day one. You have the patient sign this three-page document when they come back 72 or more hours later for the actual surgical abortion. Do I understand that correctly?

THE WITNESS: Yes.

MS. SWANSON: Objection to form.

THE WITNESS: That is correct that we have them sign this form at the time of the procedural abortion.

Q. (Mr. Boyle) When do they pay for the surgical abortion?

A. I don't participate in the payment process,

but I believe -- it's my understanding the patient pays for the abortion on the day of the abortion.

Q. So not the first day that triggers the 72-hour clock. It's when they come back for the day of the actual surgical abortion after at least 72 hours have passed. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: It is my understanding that the patient only pays for the services they receive. So on day one, they might pay for the ultrasound or labs if they received them. But they do not pay for the abortion on the day of the consent process, because they cannot receive the abortion on that day.

Q. (Mr. Boyle) You charge your patients an independent fee for performing an ultrasound. Is that right?

MS. SWANSON: Objection to form.

THE WITNESS: I did not create the forms or create the fee schedule. But my understanding is that a patient who's self paying for an abortion would be charged $625 for the entire abortion procedure, including the pretesting that we do.

And if that pretesting occurs 72 hours in advance, including the ultrasound, they pay that

portion and then they would pay the remainder to reach the total on the day of their abortion.

Q. (Mr. Boyle) Do you know how much it costs to have the ultrasound?

A. I do not recall that number.

Q. I think you also said that there's an independent separate charge for performing blood work also.

A. If the patient has blood work as part of their 72-hour consent, then that charge is paid on day one and reduced from the total that is owed on the second day.

Q. But if they don't come back, then they've paid whatever for that blood work and that ultrasound. They don't have to pay the balance of the 625, but they also don't get a refund for what they paid for the ultrasound and the blood work. Is that correct?

A. The patient only pays for the services they receive on day one, and those are not reimbursed if they choose not to return for their abortion.

Q. Do you give an ultrasound to every patient who tests positive for pregnancy at PPSAT?

MS. SWANSON: Objection to form.

THE WITNESS: No, we don't perform an ultrasound on every patient who tests positive for

pregnancy at PPSAT.

Q. (Mr. Boyle) Do you give an ultrasound to every patient who tests positive for pregnancy at PPSAT who elects to have a chemical abortion?

MS. SWANSON: Objection to form.

THE WITNESS: We do require that every patient who has a medication abortion at PPSAT has had an ultrasound prior to that abortion.

Q. (Mr. Boyle) When you say, "an ultrasound prior to that abortion," can you be a little more specific? Is there a time frame?

A. The ultrasound would have had to have taken place during this pregnancy. Yes.

Q. That's what I'm asking about.

A. Yes.

Q. I figured, but lawyers like to clarify.

Okay. So as I understand what you just said, if there is a patient at PPSAT who tests positive for pregnancy and elects to have a chemical abortion, 100 percent of the time, PPSAT either takes their own ultrasound if there isn't one already on file, or PPSAT reviews a recent ultrasound from this particular pregnancy for that patient. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: It is correct that we

require that there is an ultrasound performed prior to any medication abortion. The vast majority of the time, we are performing that ultrasound, but there are cases where we would accept an ultrasound from an outside source.

Q. (Mr. Boyle) Related to that particular patient's current pregnancy?

A. From this current patient that we are performing an abortion on during this pregnancy. Correct.

Q. So it's fair to say -- and I will tell you, it did not appear that way to me reading the protocols. But I want to clarify that PPSAT does not perform any chemical abortion on a patient who has tested positive for pregnancy without reviewing at least one ultrasound, whether they took it or whether it was taken outside the facility and provided to PPSAT. Is that correct?

A. That is correct, in the state of North Carolina.

Q. Clarification understood. State of North Carolina. Has that been PPSAT's practice in North Carolina about always having at least one ultrasound before giving a medication abortion to a patient before -- you know, prior to July 1st, 2023?

A. That has been the practice throughout my entire time ---

Q. Okay.

A. --- at Planned Parent South Atlantic.

Q. So since 2009 when you arrived, it's been the same up to today.

A. It has been the practice to perform an ultrasound prior to medication abortion.

Q. Do you -- does PPSAT provide deep sedation at any of its North Carolina clinics?

A. No, we do not.

Q. If you look at Page Bates Number 39, please. And as you're getting there, I'll ask, do you require, or is it your understanding that there has to be an anesthesiologist or CRNA or some specialist who has anesthesia specialization in medicine in order to have a patient receive deep sedation for a procedure?

MS. SWANSON: Objection to form.

THE WITNESS: It is my understanding of the PPFA protocols that a CRNA or an anesthesiologist is required for deep sedation.

Q. (Mr. Boyle) Do -- does PPSAT have any anesthesiologists who perform anesthesia services at any of its six clinics in North Carolina?

A. No, we do not.

Q. Same question for CRNAs.
A. No, we do not.
Q. So PPSAT does not have any anesthesia specialists who perform anesthesia services at any of the clinics in North Carolina. Is that correct?
MS. SWANSON: Objection to form.
THE WITNESS: It is correct that PPSAT does not hire anesthesiologists or CRNAs, because we do not perform deep sedation.
Q. (Mr. Boyle) Okay. So when you look at Bates Number 39, in the middle there, do you see there's a box that says, "I would like to receive, Select one: moderate, deep sedation and have read and understood -- and understand the risks and benefits outlined above"?
Do you see that?
A. I see that.
Q. So you're saying that, despite what this says, that the patient has an option of choosing deep sedation, that that's just wrong on this form, and PPSAT North Carolina does not provide deep sedation?
A. The patient is only permitted to select moderate sedation or minimal sedation or no sedation at PPSAT.
Q. But the form here says, "deep sedation," doesn't it?

A. The form says, "deep sedation." It is not an option that the patient can select.

Q. So the form is inaccurate.

MS. SWANSON: Objection to form.

THE WITNESS: The form is -- I can't speak to the accuracy of the form. I can tell you that patients are not offered the option of deep sedation at PPSAT.

Q. (Mr. Boyle) Well, you're reading the same form I am that says it gives the patient the option of choosing deep sedation, right?

MS. SWANSON: Objection to form.

THE WITNESS: The patient is not allowed to choose deep sedation.

Q. (Mr. Boyle) Then what happens when the patient just reads this form, sees deep sedation as an option, and selects it?

MS. SWANSON: Objection to form.

THE WITNESS: The patient is informed that deep sedation is not an option at a Planned Parenthood clinic.

Q. (Mr. Boyle) Okay. And I'm not saying I don't believe you. I just -- this gave me pause, because I didn't know if you all were doing deep sedation. It sounds like the answer is categorically,

"No."

A. We are not providing deep sedation.

Q. Who witnesses these forms, this Bates 39 and Bates 36?

A. The forms are witnessed by the staff member who reviews the forms and has the patient sign them, so the person who sees the patient sign the form witnesses their signature.

Q. And that's different than what we were talking about with the State law 72-hour requirement witness. That has to be someone who is one of those categories: the nurse, nurse practitioner, midwife, doctor or PA. Correct?

MS. SWANSON: Objection to form.

THE WITNESS: It is correct that the 72-hour advance form provided by the State must be done by one of those select licenses. That person reviews the form and witnesses the patient's signature.

Q. (Mr. Boyle) Now, I haven't seen that form. Does it include a description of risks of the procedure?

A. I ---

MS. SWANSON: Objection to form.

THE WITNESS: --- have not looked at that form in detail in recent days, but it does involve

some information about risks of abortion. To speak in any detail, I would need to look at the form.

Q. (Mr. Boyle) When a patient is there, day of, looking at these documents that we have in this package in front of us and is signing Bates Number 36 or signing Bates Number 39, and it's witnessed by someone who is a staff member at PPSAT, that staff member is not -- typically not a licensed practitioner who will be able to answer that patient's questions about risks of a procedure or risks of anesthesia. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: No, that is not correct.

Q. (Mr. Boyle) What's incorrect about it?

A. All of our staff are trained to answer routine questions that patient asks -- patients ask about the risks, and all of our staff are trained to have a licensed provider come in and answer questions that they do not know how to answer or any additional questions that the patient may have.

Q. What steps do you take to ensure that a patient who is getting mild or moderate sedation for a surgical abortion at a PPSAT clinic doesn't drive away from that clinic after the procedure?

A. We review, with any patient who is receiving

minimal or moderate sedation, that they are not allowed to drive, with the exception of nitrous used for minimal sedation, which does not preclude the patient from driving. We review with them, ideally at the time of scheduling, that they cannot receive sedation and drive after the procedure.

Q. Do you take any steps when that patient shows up on the day of the procedure for that surgical abortion to ensure that they didn't just drive themselves, and they have someone to drive them after they've received that mild or moderate sedation?

A. May I look at the form?

Q. Absolutely. Just orient us to a Bates ---

A. Yeah ---

Q. --- Number, if you don't mind.

A. --- I'm looking at Bates Page 39. And in the second box at the top of the document, we review with the patient that in order to receive and consent to receiving minimal or moderate sedation, they have to agree that they will not drive, operate heavy machinery or make important decisions for at least 12 hours after sedation or analgesic.

Q. You said that this box says you make sure that in order to receive mild or moderate sedation, they will not drive and they will not operate heavy

machinery, and they will not make important life decisions for the next 12 hours, right?

MS. SWANSON: Objection to form.

Q. (Mr. Boyle) That's what you said.

A. What I did was read this statement that the patient is required to review prior to consenting to sedation.

Q. Right. But it doesn't say that they agree to it. It just says, "do not drive," "do not operate heavy machinery," "do not make important decisions."

My question is, what do you do to ensure that they didn't drive there themselves and that they have someone else or some other mechanism of transportation to get them from the clinic to wherever they're going, their home or somewhere else? Do you take any steps to verify that?

MS. SWANSON: Objection to form.

THE WITNESS: We do confirm with the patient that they have a plan for leaving the clinic that does not involve them driving.

Q. (Mr. Boyle) That's not something you record in these documents, though, is it?

A. The driver is not recorded in this document. Our electronic health record, if the patient has a driver that we'll be contacting when it's time to pick

the patient up, does record the name and phone number of their driver.

Q. Do you agree that an unborn child is typically viable outside of the mother's womb after 24 weeks of gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: That is not my specialty, and I do not have significant training or knowledge about pregnancy viability dates.

Q. (Mr. Boyle) So you've performed abortions for the past 13 and a half years at least, and you're not able to say when you think a child is typically viable, at what gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I'm saying that is not my area of expertise. And I have not performed or participated in abortion in the last 20 years -- no, in the last 15 years, that occurred past 20 weeks. So my area of expertise is more in abortions under 20 weeks.

Q. (Mr. Boyle) And that's fair enough. And I'm not saying you should know. I'm just trying to clarify. You don't know at what gestational age, you're not able to say -- as a family practice doctor, who performs abortions, you are not able to say when you think an unborn child is viable and whether that's

after 24 weeks or some other time. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: I understand fetal viability to be approximately 24 weeks but have a great deal to do with the circumstances of the fetus, and that there are experts who know much more about that than I do.

Q. (Mr. Boyle) Do you agree that abortion should not be banned at any point during a pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: I do not believe that abortion should be banned. I think that the decision to have an abortion should be made by a healthcare provider and a patient based on their individual circumstances.

Q. (Mr. Boyle) And that's probably a better way to say it. So if I understand that, you think that abortion should be allowed up to the full term of prior to giving birth, but -- up until basically an unborn child is ready to be born. Is that correct?

MS. SWANSON: Objection to form.

THE WITNESS: No, I don't believe that abortion occurs at term. If a fetus needs to leave the uterus at term, it is a delivery, not an abortion.

Q. (Mr. Boyle) Okay. Do you think that

abortion should occur -- induced abortion should occur at, say, 35 weeks of gestational age?

MS. SWANSON: Objection to form.

THE WITNESS: I think that if a patient had tragic circumstances that necessitated no longer carrying a fetus at 35 weeks, that the decision about how to handle that should be based entirely on the patient's circumstances and be a decision between the patient and their healthcare provider as to whether delivery or termination is the most appropriate next step.

Q. (Mr. Boyle) Based on that, do you think that the former North Carolina law that restricted abortion generally after 20 weeks was too restrictive?

MS. SWANSON: Objection to form.

THE WITNESS: I think there are medical circumstances beyond 20 weeks that patients should absolutely have access to abortion care.

Q. (Mr. Boyle) Do you agree that if there is a safety reason to take some medical action, it can be considered a rational decision to take that action?

MS. SWANSON: Objection to form.

THE WITNESS: I believe that safety is one of the very important factors that should be considered any time we are making a decision about an

action.

Q. (Mr. Boyle) Do you use a differential diagnosis in your clinical practice?

A. Yes, I do consider a differential diagnosis in my clinical practice.

Q. Do you agree that a differential diagnosis should include all of the possible risk or dangerous situations for a patient that you are providing medical care to?

MS. SWANSON: Objection to form.

THE WITNESS: I believe that a differential diagnosis should include the most likely or most common. I think stating all possible outcomes is something that can never truly be known.

Q. (Mr. Boyle) Do you agree that if you're treating a patient and there's something on that patient's differential diagnosis that could be life threatening, that you should treat that and rule it in or rule it out before you stop considering it as something of importance on your differential diagnosis?

MS. SWANSON: Objection to form.

THE WITNESS: I don't understand what you're asking.

Q. (Mr. Boyle) If you're treating a patient and you develop a differential diagnosis, and it includes

on that differential diagnosis something that could be life threatening, you're not sure if it's there or not, don't you agree that you need to rule it in or rule it out before you cross it off your list on your differential diagnosis?

A. I believe you need to rule it in or out before you remove it from your differential diagnosis, but not that you need to rule it in or rule it out before you provide some treatment to the patient. They can be done concurrently. And I'd like to clarify, that can be done concurrently in some cases.

Q. You agree, though, that the concept of the differential diagnosis is you treat the worst first, right?

MS. SWANSON: Objection to form.

THE WITNESS: I think that's too vague a statement for me to be able to answer.

Q. (Mr. Boyle) So if you've got a patient who comes in and they're having pain in their chest, it could be heartburn. But it could be a heart attack, right?

A. Those are two things in a differential diagnosis for chest pain.

Q. And a heart attack could kill that patient, right?

MS. SWANSON: Objection to form.

THE WITNESS: Heart attacks can be life threatening, yes.

Q. (Mr. Boyle) Heartburn is probably not going to kill that patient, is it?

A. Heartburn is usually not life threatening.

Q. If you have a patient who comes in, and they have an unknown diagnosis with symptoms of things that are not life threatening but also could be life threatening, you've got to look at that life-threatening diagnosis and treat that and rule it out, don't you?

A. Actually, it depends a great deal on the patient. In my experience of managing patients with chest pain, the decision to rule out heart attack would be based on the patient's risk factors, age and the likelihood that the pain they were feeling was a heart attack.

Q. What is the American College of Obstetricians and Gynecologists?

A. I understand it to be an organization supporting OB/GYN and ancillary providers of obstetrical and gynecologic care.

Q. And we'll call it ACOG. Is that your understanding of the ---

A. That's ---

Q. --- acronym?

A. --- my understanding of the acronym.

Q. Okay. Are you a member of ACOG?

A. Yes, I am.

Q. Do you agree that the ACOG practice bulletins provide clinical management guidelines for -- excuse me, OB/GYNs and people who are providing similar services to OB/GYNs?

A. I have not reviewed every ACOG bulletin. I understand that they are intended to provide guidance.

Q. Do you review ACOG bulletins on occasion?

MS. SWANSON: Objection to form.

THE WITNESS: I do review some ACOG bulletins.

Q. (Mr. Boyle) When you have a woman who you are seeing as a patient who has a positive pregnancy test result, what is on her differential diagnosis as potential medical issues and risks, in your mind?

MS. SWANSON: Objection to form.

THE WITNESS: The depth of what I would consider as risks would depend on the context in which I was seeing a patient with a positive pregnancy test.

Q. (Mr. Boyle) Okay. You have a patient who has a positive pregnancy test that comes into PPSAT and

is discussing with you the possibility of having a chemical abortion. What would you have on that patient's differential diagnosis?

A. I do not routinely make a differential diagnosis based on a positive pregnancy test. When I'm seeing a patient for a medication abortion, I have ultrasound information. And so I'm basing my decisions not on the pregnancy test, but on the ultrasound results, in most cases.

Q. Okay. If you get an ultrasound result from a patient who's tested pregnancy -- sorry, tested pregnant -- tested positive for pregnancy. Start over.

If you have a patient who has tested positive for pregnancy and you get an ultrasound result for that patient, what is on your differential diagnosis for that patient?

MS. SWANSON: Objection to form.

THE WITNESS: My differential diagnosis would be based on the results of the ultrasound.

Q. (Mr. Boyle) And what are the options there?

MS. SWANSON: Objection to form.

THE WITNESS: The most common options in a pregnant patient when I am looking at their ultrasound would be one of five categories. Would you like me to outline those categories?

Q. (Mr. Boyle) Please.

A. Definite intrauterine pregnancy, probable intrauterine pregnancy, definite ectopic pregnancy, probable ectopic pregnancy and pregnancy of unknown location. There are some other things that could be considered, but those are the main five categories.

Q. Okay. What is your differential diagnosis for the patient who has definite intrauterine pregnancy?

A. If I have diagnosed a definite intrauterine pregnancy? I have diagnosed a definite intrauterine pregnancy, so the differential -- I'm not sure what you mean by, "What differential diagnosis do you have?"

Q. Fair enough. If you have, category one, a patient who has an ultrasound with a definite intrauterine pregnancy, do you include ectopic pregnancy on that patient's differential diagnosis?

MS. SWANSON: Objection to form.

THE WITNESS: When we are doing an ultrasound, we routinely evaluate the adnexal with every ultrasound we do. We do not always -- we routinely do a full sweep of the uterus and adnexal on all ultrasounds.

If someone has a definite intrauterine pregnancy, then the likelihood that there is another

diagnosis is small, although other diagnoses that I have seen have been molar pregnancy or partial molar pregnancy, early pregnancy failure or miscarriage, twin pregnancy. There can be other things in addition to an intrauterine pregnancy.

Q. (Mr. Boyle) What is twin pregnancy? What is that?

A. Twin pregnancy is generally understood as a pregnancy that contains either two gestational sacs and/or two fetal poles.

Q. (Mr. Boyle) So twins?

A. Correct.

Q. Okay.

MS. SWANSON: I'd just like to note that we've been on the record for about another hour, so if we could wrap up for lunch when you come to a good stopping point, that'd be great.

MR. BOYLE: That's fine with me.

THE VIDEOGRAPHER: Off record, 12:31.

(Lunch Break: 12:31 p.m. to 1:07 p.m.)

THE VIDEOGRAPHER: On record, 1:07.

MS. SWANSON: Before we get started, I'd like to note for the record that my colleague, Helene Krasnoff, from Planned Parenthood Federation of America for Planned Parenthood South Atlantic, has joined us.

Q. (Mr. Boyle) All right. We ready, Doctor?

A. I am.

Q. Very good. Thank you. Do -- does PPSAT ever offer informed consent, like we were talking about, the second -- the returned trip informed consent, like Bates Number 36 and Bates Number 39 we were looking at, in a group setting to patients, or is it always a one-on-one, employee talking to an individual patient?

MS. SWANSON: Objection to form.

THE WITNESS: Our protocol is to offer informed consent one on one.

Q. (Mr. Boyle) Okay. So it doesn't happen with, like, five or ten patients sitting in a room with one employee giving them all the paperwork and having them all sign it at the same time?

A. No, it does not.

Q. Okay. I think we stopped on differential diagnosis for Category Number 1, when you have an ultrasound with a patient who has a definite intrauterine pregnancy.

Is there a difference between what you said the differential diagnosis is for that patient, with an ultrasound showing an intrauterine pregnancy, versus Category 2, an ultrasound showing possible intrauterine pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: So the second category I referred to, we call a probably intrauterine pregnancy. And I don't know how to answer the question, "Is there a different differential diagnosis?" I'm not really clear what you're asking.

Q. (Mr. Boyle) Is your differential diagnosis the same or different compared -- Category 1 to Category 2?

MS. SWANSON: Objection to form.

THE WITNESS: I would say it was different. One of the common ways we would see a probably intrauterine pregnancy would be in someone who had a large, empty uterine sac. And depending on the size of that sac, would make us either suspicious for, or clinically certain, that the patient was experiencing a miscarriage.

Q. (Mr. Boyle) Okay. How about for Category 3, which I believe you said was an ultrasound that definitely showed an ectopic pregnancy? What's your differential diagnosis for that patient?

MS. SWANSON: Objection to form.

THE WITNESS: I would consider that patient to have an ectopic pregnancy or a pregnancy outside the uterus.

Q. (Mr. Boyle) And what would you do as a result of that?

A. If I see a patient with an ectopic pregnancy, I refer them for treatment of that pregnancy.

Q. Refer them where?

A. Either to their primary gynecologist, if that's their preference, and they're able to see them quickly, or to a hospital for care.

Q. Because an ectopic pregnancy is a life-threatening risk for a patient, isn't it?

MS. SWANSON: Objection to form.

THE WITNESS: An ectopic pregnancy can be life threatening if not treated, yes.

Q. (Mr. Boyle) Because it's a pregnancy growing outside of the uterus, where it's supposed to be, and it can cause -- if it's in the fallopian tubes, it cause those to rupture and bleed, right?

A. That is one form of ectopic pregnancy. There are many locations that an ectopic pregnancy can exist, including technically within the uterus.

Q. Okay. And if you have -- well, the fourth category would be an ultrasound that showed a suspected ectopic pregnancy. How would your differential diagnosis for that fourth category differ, if any way, from the third category, where you actually identified

ectopic pregnancy?

A. So a probable ectopic pregnancy would mean that I am seeing something outside of the uterus that I am suspicious is ectopic, but I don't see characteristics that absolutely confirm that that is a pregnancy that I'm seeing versus some other structure such as an ovarian cyst that's complex.

Q. And what would your differential diagnosis -- what would you do with that patient, that Category 4?

(Knock at door)

Q. You can continue. You can continue. I'm listening.

MR. BOYLE: Thanks.

THE WITNESS: Differential diagnosis and treatment are two very different things. Would you like me to answer what the differential diagnosis was or what I would do for it?

Q. (Mr. Boyle) Start with the differential, yes.

A. So the differential diagnosis of a probable ectopic pregnancy is would be that there is an ectopic pregnancy that I can't definitely diagnosis or that there is some other structure outside of the uterus that I -- that could be a complex ovarian cyst, it

could be some other structure outside of the uterus such as bowel that has a strange appearance.

Q. If it was a cyst instead of an ectopic pregnancy, would you consider that patient to be at risk of danger from that cyst?

MS. SWANSON: Objection to form.

THE WITNESS: Some cysts can create danger, but rarely the more immediate, potentially life-threatening danger of an ectopic.

Q. (Mr. Boyle) Okay. So what would you do with that patient if you -- you couldn't tell if it was an ectopic pregnancy, but you saw something and you suspected it might be a cyst? What would you do?

A. If I saw something outside of the uterus that I would categorize as a possible ectopic pregnancy, even if I thought there was a reasonable possibility that it was a cyst, if it falls under the category of probable ectopic pregnancy, I would treat it as an ectopic pregnancy, where I would refer the patient ---

Q. Okay.

A. --- for immediate evaluation.

Q. And that makes sense, because an ectopic pregnancy is a potentially life-threatening condition. So if you have a strong suspicion for it, you have to rule it out, so you go ahead and refer that patient to

their gynecologist or an emergency room so that she can get worked up further, and they can rule it out or rule it in. Is that fair?

MS. SWANSON: Objection to form.

THE WITNESS: If a patient has a definite or probable ectopic pregnancy, that means that I am concerned about a potentially life-threatening condition, and I would refer them for further immediate evaluation.

Q. (Mr. Boyle) A patient with the fifth category, pregnancy of unknown location, could that be an ectopic pregnancy?

A. It could be.

Q. Are you suspicious that it might be an ectopic pregnancy?

MS. SWANSON: Objection to form.

THE WITNESS: No. If I'm suspicious that it might be an ectopic pregnancy, then I would consider it a probable or definite ectopic pregnancy.

Q. (Mr. Boyle) So if you have a pregnancy of unknown location on an ultrasound, you're not seeing an actual pregnancy or possible pregnancy either in the uterus or outside the uterus, correct?

A. Correct.

Q. Doesn't that raise your suspicion that that

patient could have an ectopic pregnancy, because you haven't ruled it out?

MS. SWANSON: Objection to form.

THE WITNESS: When I have a patient who has a probable -- or, pardon me, who has a pregnancy of unknown location, I consider three -- the most common three possibilities in my differential diagnosis: that they have an early intrauterine pregnancy that is not yet visible; that they have an early intrauterine pregnancy that is undergoing miscarriage; or that they have an ectopic pregnancy that is not yet visible.

Q. (Mr. Boyle) So when you have a Category 5, pregnancy of unknown location, on an ultrasound, part of your differential diagnosis is Number 3, that they may have an ectopic pregnancy that you just can't see yet?

A. That is correct. That is part of the differential diagnosis.

Q. Unless they are discovered and treated early, you would agree that almost 40 percent of ectopic pregnancies rupture suddenly, causing pain and bleeding in the abdominal cavity, wouldn't you?

A. I do not have that data.

Q. You don't know that data?

A. I do not know that statistic off the top of

my head.

Q. You would agree, at least, that ruptured ectopic pregnancies can be fatal, wouldn't you?

A. I would agree.

Q. At least 2 percent of pregnancies are ectopic pregnancies. Isn't that right?

A. The categorization I have heard is that up to 2 percent of pregnancies are ectopic pregnancies.

Q. We were talking about ACOG before. Are you familiar with ACOG Practice Bulletin 193?

A. I would have to look at it to know.

Q. You don't know it just off the top of your head?

A. Not from a number.

Q. Okay.

MR. BOYLE: I'm going to hand you a document.

MS. SWANSON: Thank you.

MR. BOYLE: You're welcome.

Q. (Mr. Boyle) Take your time, review that please, and let me know when you're ready to identify it.

A. I have not read it in detail, but I am -- I do have it in front of me.

Q. Okay. Are you able to identify what this is,

please?

A. It is the ACOG Practice Bulletin, Number 193.

Q. And from what -- what time frame?

A. From March 2018.

Q. What's the topic of this Practice Bulletin?

A. Clinical Management Guidelines for Obstetrician/Gynecologist Tubal Ectopic Pregnancy.

Q. Do you see on the first page, under Background/Epidemiology, where it says, quote, "According to the CDC, ectopic pregnancy accounts for approximately two percent of all reported pregnancies," end quote?

A. Yes, I see that quote.

Q. You see a few lines down where it says, quote, "Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity. In 2011 to 2013, ruptured ectopic pregnancy accounted for 2.7 of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality," end quote?

You see that?

A. Yes, I see that.

Q. Do you agree with that?

A. I do trust this data.

Q. Okay. If you look over that Risk Factor section on the first page, I'm going to read you a sentence and ask you about that. First sentence says, quote, "One-half of all women who receive a diagnosis of an ectopic pregnancy do not have any known risk factors," end quote. Do you see that?

A. I do see that.

Q. So you would agree that it's possible that a woman who comes into a PPSAT clinic has an ectopic pregnancy but doesn't have any known risk factors for that ectopic pregnancy?

A. Yes, that is possible.

Q. And the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus seen in the uterus. Isn't that right?

A. I don't know ---

MS. SWANSON: Object to form.

THE WITNESS: --- what you mean by, "gold standard."

Q. (Mr. Boyle) You don't use the word -- the term "gold standard" in your medical practice?

A. I would not use the term "gold standard" in this context.

Q. Do you use it in any context in your medical

practice?

MS. SWANSON: Objection to form.

THE WITNESS: I don't know that I -- it's not a -- it's not a term that I routinely use, no. I would say that ultrasound is a critical factor in diagnosis of ectopic pregnancy.

Q. (Mr. Boyle) I will accept that. If you turn to the second page of this Bulletin 193, under Clinical Considerations and Recommendations, How is an Ectopic Pregnancy Diagnosed; you see that section?

A. I do see that section.

Q. Okay. You see the sentence that says, quote, "The minimum diagnostic evaluation of a suspected ectopic pregnancy is transvaginal ultrasound evaluation and confirmation of pregnancy," end quote. Do you see that?

A. I do.

Q. So ACOG requires, according to this Bulletin, that in order to rule in or rule out an ectopic pregnancy, you have to have an ultrasound that shows the pregnancy. Is that correct?

A. That ---

MS. SWANSON: Objection to form.

THE WITNESS: That's not actually what it's saying. What it's saying is that the minimum

diagnostic evaluation, so the minimum you must do if you suspect ectopic pregnancy, is a transvaginal ultrasound evaluation.

And when they say, "and confirmation of pregnancy," they mean that if you do a transvaginal ultrasound but you haven't done another test to confirm that the patient is pregnant, such as a urine or blood pregnancy test, then it's not as useful.

For example, if a patient had a negative pregnancy test, then the -- the transvaginal ultrasound wouldn't be helpful. So if you do a transvaginal ultrasound and don't see a pregnancy, you would next do a pregnancy test to see if the patient was even pregnant.

Q. (Mr. Boyle) So you think that sentence there, that's talking clearly about ultrasound, means that a doctor doesn't have to actually confirm the pregnancy with the ultrasound? That's how you interpret that sentence?

MS. SWANSON: Objection to form.

THE WITNESS: No. What I am saying is that this sentence says that you must do an ultrasound, and you must also confirm that the patient is pregnant. Because often, for example, in pregnancy of unknown location, you will do an ultrasound and not see a

pregnancy.

So if you perform an ultrasound, which is often done before a pregnancy test is done, and you see no pregnancy, the very next step is to perform a pregnancy test to confirm that the patient is pregnant. Because if the patient is not pregnant, then the concern for ectopic pregnancy no longer exists.

Q. (Mr. Boyle) I just want to make sure that I understand what you're saying. The next sentence says, quote, "Serial evaluation with transvaginal ultrasonography, or serum HCG level measurements, or both, often is required to confirm the diagnosis," end quote.

Do you see that?

A. Yes, I see that.

Q. And you think that, again, when the prior sentence says, "confirmation of pregnancy," it's not talking about with an ultrasound, it's talking about with a pregnancy test?

MS. SWANSON: Objection to form.

THE WITNESS: I believe that the first sentence is saying that a transvaginal ultrasound in the absence of confirming that the patient is actually pregnancy is not helpful. So you confirm that the patient is pregnant.

And then, I believe, that you must perform not just one ultrasound, unless the ultrasound definitely diagnoses an ectopic pregnancy. If it does not give you a definitive diagnosis, then the next step is to perform serial ultrasounds, usually over the course of several days, and often, serial blood tests, usually over the course of several days.

Q. And I guess I'm -- I'm confused, and maybe I'm just ignorant to this. It's entirely possible. When a woman comes to PPSAT and says, "I think I might be pregnant," isn't the first step, you just give her a pregnancy test as opposed to giving her an ultrasound?

A. It depends on the type of visit. If a patient comes in and says, "I'm not sure if I'm pregnant. I'd like to find out," we perform a pregnancy test.

Most of the patients who are coming to us for abortion come and say, "I did a pregnancy test at home. I'm here for an abortion." In those patients, we start with ultrasound, because they've already performed an equivalent pregnancy test at home.

Q. So -- and that second type of patient, when they show up and say, "I did a pregnancy test at home. I think I'm pregnant. I want an abortion," you perform an ultrasound first.

And then, if you don't see a pregnancy on the ultrasound, that fifth category, pregnancy of unknown location, then you give them the pregnancy test?

A. That's correct.

Q. How much does it cost to give them a pregnancy test?

A. I don't know the cost of pregnancy tests, and I don't know that we actually charge for the pregnancy test in that setting. I'm not sure.

Q. But you charge for the ultrasound?

A. We do charge for the ultrasound.

Q. Why wouldn't you just give them a pregnancy test first, especially if it doesn't cost the patient any money?

MS. SWANSON: Objection to form.

THE WITNESS: We almost never have to do a pregnancy test. If we were performing a pregnancy test on every single patient, I think we probably would have to charge for it.

So a vast majority of patients come to us and say they've had a positive pregnancy test. If a patient came to us and said, "I'm not sure if I'm pregnant," we would start with a pregnancy test before an ultrasound.

Q. (Mr. Boyle) If you look at the next column

over, Serum Human CH -- CG -- HCG, sorry. Serum HCG Measurements, do you see that?

A. I see that.

Q. It says, quote, "Measurement of the Serum HCG levels aids in the diagnosis of women at risk of ectopic pregnancy. However, Serum HCG values alone should not be used to diagnosis an ectopic pregnancy and should be correlated with the patient's history, symptoms, and the ultrasound findings," end quote.

Do you see that?

A. I see that.

Q. So doesn't that say that you have to see an ectopic pregnancy by an ultrasound, either saying it's intrauterine or it's not?

MS. SWANSON: Objection to form.

THE WITNESS: No, that's not at all what it says.

Q. (Mr. Boyle) Okay. If you have a woman who has tested pregnant -- tested positive for pregnancy, and you take an ultrasound of her and you don't see a fetus or an embryo anywhere on that ultrasound, doesn't that actually raise your suspicion for her having an ectopic pregnancy on that differential diagnosis you were discussing earlier?

A. Yes, it does increase my suspicion for

ectopic pregnancy if I do not see a pregnancy either inside or outside of the uterus, including a gestational sac, not just a fetus or embryo.

Q. Okay. When you're treating a -- a woman who's tested positive for pregnancy, but she has a confirmed ectopic pregnancy, you don't provide her with the two chemical abortion drugs, do you?

A. That is correct. We do not treat anyone with a confirmed ectopic pregnancy with medication abortion medications.

Q. Because mifeprex (sic) and misoprostol are drugs that do not assist a woman in treating her for her ectopic pregnancy, are they?

MS. SWANSON: Object to form.

THE WITNESS: Mifepristone and misoprostol, as used in medication abortion, are not effective in treating ectopic pregnancy.

Q. (Mr. Boyle) And the FDA label says that they are contraindicated in patients with confirmed or suspected ectopic pregnancies, doesn't it?

A. I don't know what the FDA label says without looking at it.

Q. You've prescribed these medications several times every week for the past 14 years, correct?

A. That is correct.

Q. And you are unaware that the FDA label says that they are contraindicated for a woman who has an actual diagnosed or suspected ectopic pregnancy?

MS. SWANSON: Object to form.

THE WITNESS: I cannot directly quote the FDA label without looking at it. I am aware that we do not use mifepristone and misoprostol, as designed for medication abortion, in patients with known or suspected ectopic pregnancy.

Q. (Mr. Boyle) A patient who has a suspected ectopic pregnancy needs to be worked up to see if she needs surgical treatment for her ectopic pregnancy or if she qualifies for a different drug treatment, methotrexate, right?

A. There are different treatments for ectopic pregnancy, and those treatments should be offered based on the patient's exact circumstances, yes.

Q. Typically, the drug you give for ectopic pregnancy is methotrexate, not the two chemical abortion drugs, right?

A. I do not treat ectopic pregnancy, but it is -- you do not use mifepristone and misoprostol to treat ectopic pregnancy. Methotrexate is one of the medications that can be used to treat ectopic pregnancy.

Q. If you give a woman who tests positive for pregnancy, who is actually suffering from an ectopic pregnancy, the chemical abortion drugs, and it does not stop her ectopic pregnancy from growing, that ectopic pregnancy can rupture, possibly in her fallopian tubes or some other internal structure, causing damage and bleeding inside her abdomen. Isn't that right?

MS. SWANSON: Object to form.

THE WITNESS: Any woman who has an ectopic pregnancy, that ectopic pregnancy can rupture if it is not treated, regardless of whether the patient receives mifepristone and misoprostol or not.

Q. (Mr. Boyle) That's fair. But the prescription of those two drugs wouldn't have any impact on whether that ectopic pregnancy will continue to grow and possibly rupture, right?

A. I don't believe it's been extensively studied, but we do not treat ectopic pregnancy with mifepristone and misoprostol. There's a possibility that they could stop the growth theoretically, but we do not use it for that purpose.

Q. Okay. I appreciate that there may be further research to be done, but there's none that you're aware of that has been done to suggest that's an appropriate treatment regimen for ectopic pregnancy. Is that

correct?

MS. SWANSON: Object to form.

THE WITNESS: I am unaware that anyone would use mifepristone and misoprostol to treat a known or suspected ectopic pregnancy.

Q. (Mr. Boyle) You agree that many of the symptoms of a ruptured ectopic pregnancy mimic, or are exactly the same as, the expected side effects of a chemical abortion that you or one of your colleagues at PPSAT have counseled your patient could occur if you give that patient a chemical abortion, right?

MS. SWANSON: Object to form.

THE WITNESS: There are some overlapping symptoms between the normal symptoms we expect with medication abortion and the symptoms of an ectopic pregnancy.

Q. (Mr. Boyle) It's possible that a patient who took chemical abortion drugs and then suffered a ruptured ectopic pregnancy, leading to internal bleeding and vaginal bleeding, pain, dizziness, headache, could misconstrue or confuse those symptoms of the ectopic pregnancy with the normal expected side effects of the chemical abortion, as it was described to her by her doctor or other provider at PPSAT. Isn't that true?

MS. SWANSON: Object to form.

THE WITNESS: It would be important to educate any patient on whom we have not diagnosed an intrauterine pregnancy, who takes mifepristone and misoprostol, on the normal symptoms that they would experience with a medication abortion and on the abnormal symptoms that they might experience, including detailed education on the symptoms of ectopic pregnancy.

Q. (Mr. Boyle) But they might confuse a ruptured ectopic pregnancy for the normal side effects from the chemical abortion process, correct?

MS. SWANSON: Object to form.

THE WITNESS: I can't speculate on who might get confused by what. It is important to give clear education and closely follow up with patients.

Q. (Mr. Boyle) If you look at the document, please, at, let's see, Bates 31, on the first page there.

MS. SWANSON: And for the record, we're now switching back to the patient education packet from the ACOG bulletin.

Q. (Mr. Boyle) Right. Bates 31. Do you see that?

A. I see that form, yes.

Q. Okay. You see on the left-hand column, it's talking about abortion pill and it's -- and it's going over what the patient may expect and how it might turn out. Is that fair?

A. I do see that form.

Q. Okay. And there's two columns. There's -- the one on the left is abortion pill, and the other one on the right is in-clinic abortion, right?

A. Correct.

Q. Okay. So when you go down to How Will I Feel, there's a list of symptoms there, right?

A. There is.

Q. It says, "nausea or vomiting, headache, dizziness." You see those?

A. I do.

Q. And then you go down two more rows and it talks about bleeding. It says, "Heavy bleeding with clots is common after taking misoprostol," right?

A. It says, "Heavy bleeding with clots is common after taking misoprostol," yes.

Q. Okay.

MR. BOYLE: I'm going to give you what's been marked as Bates Number 119 and 120.

MS. SWANSON: Thank you.

MR. BOYLE: You're welcome.

Q. (Mr. Boyle) Ask you if you recognize that document?

A. Yes, I do.

Q. And actually it's two documents there, but they're actually separate documents, I believe. Are these given out to your patients at PPSAT?

A. They are given out to some patients at PPSAT, yes.

Q. Not to every patient?

A. No, not to every patient.

Q. Okay. And when we're looking at Bates Number 119, what's the name of this document up at the top, please?

A. Positive Pregnancy Test No Pregnancy Seen on Ultrasound.

Q. Okay. So this is a document, a one-page document, about what we were talking about, that Category 5, pregnancy of unknown location from an ultrasound, right?

A. Correct.

Q. Okay. Look at the second document, Bates Number 120. What's the topic of this particular document?

A. The title of this document is Ectopic Pregnancy.

Q. Okay. And let's stay with 120 there, Bates Number 120, the ectopic pregnancy. Do you see the box that says, "What are the symptoms of ectopic pregnancy"?

A. Yes, I do.

Q. And it says, "Bleeding from the vagina may be heavy or light," right?

A. I see that.

Q. Okay. It says, "Dizziness or fainting," right?

A. I see that.

Q. Okay. Those are similar symptoms that are found on Bates Number 31, talking about what might happen to a patient after they take the chemical abortion drugs, right?

MS. SWANSON: Object to form.

THE WITNESS: There are similarities between the two forms.

Q. (Mr. Boyle) There are similarities between the symptoms that you tell a patient might -- a patient might experience with ectopic pregnancy as the side effects and symptoms you expect the patient to experience after they take the chemical abortion drugs, right?

A. There are similarities, but they are not

identical, yes.

Q. Dizziness is identical, isn't it?

MS. SWANSON: Object to form.

THE WITNESS: There are similarities between the symptoms you asked me, so not ---

Q. (Mr. Boyle) I'm asking, dizziness is in both of them, isn't it?

A. Some of the words in both, some of the symptoms use the identical words. But the entirety of symptoms you might expect are not identical between the two conditions.

Q. You said, "the entirety of the symptoms you might expect," but neither one of these, Bates Number 31 or Bates Number 120 says, "You will experience all of these symptoms if you are taking the medical chemical abortion drugs," or, "You will experience all of these symptoms if you have an ectopic pregnancy," do they?

A. That is correct.

Q. They just say these are some things that may exist under the -- that circumstance or this circumstance, right?

A. That is correct.

Q. You agree that it's possible that a patient who received a chemical abortion drug -- drugs from

PPSAT, and also was suffering from a ruptured ectopic pregnancy, could look at these forms and be experiencing symptoms from both of them and be mistaken that they think it's from the chemical abortion drug, right?

MS. SWANSON: Object to form.

THE WITNESS: Can you repeat that question, please?

Q. (Mr. Boyle) You agree that a patient from PPSAT could receive chemical abortion drugs, and also have a ruptured ectopic pregnancy at the same time or shortly thereafter, and experience overlapping symptoms that are found in both documents and confuse the ectopic pregnancy rupture for a normal side effect from the chemical abortion drug, right?

MS. SWANSON: Object to form.

THE WITNESS: I would actually clarify that the symptoms listed are for the presence of ectopic pregnancy, and not for the presence of a ruptured ectopic pregnancy.

And the presence of a ruptured ectopic pregnancy tend to be much more severe, so it is unlikely to me, clinically, that a patient would experience a ruptured ectopic pregnancy and only experience, in the example you gave, dizziness.

Q. (Mr. Boyle) Right. But it says, on Bates Number 120, "Call us right away if you have dizziness, bleeding from the vagina," down at the bottom. Do you see that?

MS. SWANSON: Object to form.

THE WITNESS: Yes, I see that statement on the document.

Q. (Mr. Boyle) And it's not like the patient is going to know that they have an ectopic pregnancy. You only see that with ultrasound. They can't look inside their own bodies, right?

MS. SWANSON: Object to form.

THE WITNESS: Patients, unless they have access to an ultrasound machine, cannot look inside their own bodies.

Q. (Mr. Boyle) Fair enough. I will grant you that. And you at least perform, or require someone else to perform and give you a copy of an ultrasound, every single time before you give a patient chemical abortion drugs, right?

A. We require that an ultrasound is performed every time before we give a patient medication abortion. And in the setting of pregnancy of unknown location, if I were to receive an ultrasound from an outside individual, I would repeat the ultrasound

myself before giving a patient medication abortion.

Q. So if you have a pregnancy of unknown location from an outside source for this patient who has just arrived and is seeking a chemical abortion, you would take another ultrasound there, at PPSAT, before you gave that patient chemical abortion drugs. Is that correct?

A. It is our protocol to repeat that ultrasound the same day, yes.

Q. You said that's in your protocols?

MS. SWANSON: Object to form.

THE WITNESS: It is our practice. I don't know exactly how it's written in our protocols without reviewing the protocols.

MR. BOYLE: And I'm handing you what has been produced in discovery as Bates Numbers 53 through 105.

Q. (Mr. Boyle) Can you just -- first, before we start, can you look at the first page and see if I'm right on the numbers there?

MS. SWANSON: And before we get started, I'm just going to state for the record that this has been produced, designated confidential under our confidentiality agreement, and not everyone who's viewing this deposition has signed that protective

agreement yet. So if you are going to be asking questions specifically that reflect the content of this document ---

MR. BOYLE: I think the way I ask this question, it won't.

MS. SWANSON: Okay.

MR. BOYLE: If it does, then ---

MS. SWANSON: I'll object.

MR. BOYLE: --- you will object, and we can address that. I suspect the answer is going to be, "No."

MS. SWANSON: Okay.

MR. BOYLE: But if it's anything other than, "No," I understand where you're coming from, and I will respect your objection as stated and we'll deal with it. I don't have a problem with that.

MS. SWANSON: I thank you.

MR. BOYLE: And I'm not making it an exhibit.

MS. SWANSON: Okay. I appreciate that.

MR. BOYLE: Yes.

Q. (Mr. Boyle) So I think we established, without going into detail, Bates Number 53 through 105 is what's been produced as Chapter 1 of the abortion chapter from PPSAT's internal protocols and guidelines.

Is that correct?

A. That is correct.

Q. Okay. I think I heard you say that you have a protocol -- and you might have said just a practice, so that's why I'm asking about the written protocols.

You have a protocol at PPSAT where, if there is a patient who has an ultrasound that gives a result of pregnancy of unknown location, and the patient has tested positive for pregnancy, so under that circumstance, and you get that ultrasound from an outside source, not internal, not done by PPSAT, that you have a protocol that requires PPSAT to do a new ultrasound.

Can you show me in this document where it says that, please?

A. Can you turn to Bates Page 64?

THE WITNESS: Am I allowed to go over what's on this?

MS. SWANSON: Let's...

MR. BOYLE: How about this? Do me a favor, and -- and I know this is bad for keeping a record. Can you just point to it on your piece of paper and let me see? And I may not have a follow-up if you show it to me just by pointing.

(Witness complies)

Q. (Mr. Boyle) Okay. You're saying that you have a policy at PPSAT that says, if a patient arrives with an ultrasound from outside a PPSAT clinic, and that ultrasound shows pregnancy of unknown location, that then, you have a protocol that says you must do a new ultrasound at PPSAT. Is that what you're saying?

A. What I'm saying is that I have a protocol that states that if I have a patient with a positive pregnancy test, in order to follow any of the next steps, I need to see that there is no gestational sac on transvaginal ultrasound.

So a transvaginal ultrasound must be done to show no -- we can't accept an outside ultrasound that has no pregnancy visible. If there's no pregnancy visible, we must do an ultrasound to see if there's a pregnancy visible.

Q. But, I guess, if that's true, why don't you just agree to the law as written, because all the law says is you have to have an ultrasound that shows an intrauterine pregnancy?

MS. SWANSON: Object to form.

THE WITNESS: Am I allowed to talk more about the protocol?

MS. SWANSON: You can talk about the protocols without referring specifically to this

document, if that's possible. If it's not possible, we can go off the record and talk about it a bit more.

THE WITNESS: If I were to receive an ultrasound from an outside organization that showed a intrauterine pregnancy, definite intrauterine pregnancy at eight weeks, four days, and I can see that that ultrasound was done four days ago, and, for example, the patient came in with their ultrasound and their consent for the procedure, our protocol would not absolutely require me to repeat that ultrasound, although the clinician always, always has the clinical prerogative to repeat the ultrasound if they have any reason they want to.

Our protocol for management of pregnancy of unknown location requires that we have an ultrasound that shows a pregnancy of unknown location. So if, for example, a patient had an ultrasound elsewhere and then came to see me at my clinic and said, "They did and ultrasound and they didn't see a pregnancy," I would not use that ultrasound clinically.

I would need to perform an ultrasound to see if the patient has a pregnancy of unknown location before proceeding with treatment.

Q. (Mr. Boyle) Okay. And if you then do that ultrasound at PPSAT and it still shows a pregnancy of

unknown location, that fifth category, you think that you should be able to simultaneously provide the chemical abortion drugs before you get the positive confirmation that that patient has an intrauterine pregnancy. Is ---

MS. SWANSON: Object ---

Q. (Mr. Boyle) --- that correct?

MS. SWANSON: Object to form.

THE WITNESS: So we follow excellent evidence-based protocols that show that it is appropriate to simultaneously determine the location of the pregnancy, which the ACOG Bulletin expresses is usually done through serial ultrasounds and/or serial blood tests, and, at the same time, provide the medication abortion to patients.

Q. (Mr. Boyle) Do you think it would be safer to give that patient another ultrasound a few days later or a week later to determine if it was an ectopic pregnancy or not, before you gave the contraindicated chemical abortion drugs?

MS. SWANSON: Object to form.

THE WITNESS: I think that it is not necessarily safer to delay starting the medication abortion for patients, and safety is one of several factors that we consider in the options that the

patient has to choose from.

Q. (Mr. Boyle) What other option -- what other factors are you considering other than the safe -- the patient's safety?

A. We are considering patient history and risks, which is part of safety. We are considering patient preference very strongly. That many patients, even if they know that if they have an ectopic pregnancy, the medications won't work.

Given that ectopic pregnancy occurs in less than 2 percent of patients, if they have no risk factors and no other concerning signs, there's a very good chance they just have an early pregnancy. My patients strongly prefer to begin definitive treatment at the same time that we are performing the serial ultrasounds and/or serial blood tests.

Q. You said you follow the evidence-based medicine. How long as PPSAT been providing medical chemical abortion drugs to patients who have pregnancy of unknown location on their ultrasound findings before confirming either ectopic or intrauterine pregnancy? How long has that been going on?

MS. SWANSON: Object to form.

THE WITNESS: I do not know exactly when that protocol was first made available to us.

Q. (Mr. Boyle) It's something that would have come, literally, across your desk as the chief medical officer, right?

A. Our protocols are updated every one to three years and different aspects of the protocols are updated at different times, so I cannot recall exactly when that update started without looking back at our historical protocols.

Q. And you just don't have any memory if you've been doing it for one year or for three years or more?

MS. SWANSON: Object to form.

THE WITNESS: That wasn't your original question.

Q. (Mr. Boyle) Well, I'm -- I know. I'm asking another question.

A. We have been doing it for at least a year, but I don't recall how long over a year we've been doing it.

Q. Okay. Because you say it's based on evidence-based medicine, what evidence-based medicine are you basing it on?

A. All of the medical standards that we use, which include the option of medication abortion while simultaneously determining the location of a pregnancy, are based on a large amount of research and data. And

we can look to the last pages to show the references, but I don't recall the exact references without actually looking at them.

Q. Can you -- can you tell me -- you can go ahead and take that. That's the Chapter 1 Abortion. Again, I'm not asking for anything really specific about it other than what you think supports your contention that providing simultaneous chemical abortion drugs to a patient with a pregnancy of unknown location is supported by any evidence-based medicine practice. And this is Bates Number 53 through 105, that document.

A. It is not possible for me, reading the titles of all of the articles that are referenced in this book, to know the full content of every article. So there are some of these articles that are very broad, which means that it is possible that the information exists in those.

Q. What page are you looking at, if I might ask?

A. I am looking at -- starting at Bates 102, and the references go through Bates 104, and I have not finished reading through every title yet.

Q. If you find any titles here that you think support your contention that there is evidence-based medicine that underlies the PPSAT's decision to, at the

same time, provide chemical abortion with a pregnancy of unknown location, please identify that for me.

MS. SWANSON: Object to form.

THE WITNESS: I would want to read through the Management of Unintended and Abnormal Pregnancy Comprehensive Abortion Care.

Q. (Mr. Boyle) Which one is that, please?

A. It's labeled throughout, and at approximately halfway down Bates 103.

Q. What's the date on that document?

A. 2009. So based on that date, it may or may not have reference to that.

Q. But you would agree that this is fairly new and evolving theory that you can provide contemporaneous chemical abortion drugs to a patient with a pregnancy of unknown location on an ultrasound, right? That research is from, like, the past two or three years, right?

MS. SWANSON: Object to form.

THE WITNESS: Without looking at the actual studies, I cannot state the exact time frame. But it is relatively new, and the newness of data does not mean that the data is not valid.

Q. (Mr. Boyle) It's come out since ACOG 193 in March of 2018, that new theory about giving chemical

abortion drugs at the same time as a patient has a pregnancy of unknown location on ultrasound, right?

MS. SWANSON: Object to form.

THE WITNESS: I don't know that. And I have not read through the entirety of ACOG Practice Bulletin 193 to see whether it references simultaneous provision of abortion while determining the location of pregnancy.

Q. (Mr. Boyle) How about you turn to the third page of the ACOG Bulletin, please? It's down at the bottom. It says, "E-93".

A. I'm on that page.

Q. Okay. If you go down to the bottom of the left-hand column, "Pregnancy of Unknown Location," you see that?

A. The -- I'm sorry, the bottom of -- yes, I do see that.

Q. Okay. So let me read this to you and then I'll ask you a question. Just making sure I've read it properly for the record.

Quote, "A pregnant woman without a definitive finding of an intrauterine or ectopic pregnancy on an ultrasound examination has a pregnancy of unknown location. A pregnancy of unknown location should not be considered a diagnosis. Rather, it should be

treated as a transient state. An effort should be made to establish a definitive diagnosis when possible," end quote.

Do you see that?

A. I see that statement.

Q. So does that inform your opinions about what was going on back in 2018, as it relates to how to diagnosis and treat a patient with -- or ultrasound of pregnancy of unknown location?

MS. SWANSON: Object to form.

THE WITNESS: I would state that it is true now that we should make efforts to establish a definitive diagnosis when possible. We are just not required to make those efforts in isolation.

Q. (Mr. Boyle) And I did not mean to interrupt you in your review of -- I apologize, I did interrupt you. I'm sorry.

You were looking at Bates Number 102, Bates Number 103 and Bates Number 104 to tell us if there was any recent research identified by PPSAT that would support its position that it is acceptable medical practice to provide chemical abortion drugs simultaneous with a patient who has a diagnosis or a transient state of pregnancy of unknown location on an ultrasound.

MS. SWANSON: Object to form. I'm not sure there's a question in there.

Q. (Mr. Boyle) The question is: show it to me, please.

MS. SWANSON: Object to form.

THE WITNESS: So I do not see some of the articles that I know are used to create those protocols. I also don't think that the list of table references are the sole source of the protocols.

Q. (Mr. Boyle) And that's fine. I was just basing that off of what I understood you to say, that they were. If you're saying they're not, then there may be other things out there that go into the protocols. Is that what you're saying?

Maybe other research out there -- I apologize, maybe other research out there that goes into making these protocols that's not included at the end in that table?

A. There is much research and expert analysis that goes into making these. I do not personally create these protocols, so cannot speak to all of the details.

Q. You would agree that induced abortions, surgical abortions, become more complicated after the gestational age is beyond 14 weeks, wouldn't you?

MS. SWANSON: Object to form.

THE WITNESS: The complexity of a procedural abortion varies throughout gestational duration. And over seven or eight weeks, I would say that there is an incremental increase in complexity of the procedure with increasing gestational duration.

Q. (Mr. Boyle) You cited the "Academies of Medicine" article, and it says that "The risk of serious complication increases with weeks gestation; as the number of weeks increase, the invasiveness of required procedure and the need for deeper levels of sedation also increase."

Do you agree with that?

MS. SWANSON: Object to form.

THE WITNESS: I can't agree that that's the exact quote without looking at the actual document. I do agree that there is an incremental increase in risk as gestational duration increases.

Q. (Mr. Boyle) I'm sorry, I'm working through here.

You agree that some second trimester induced abortions must take place in a hospital setting, don't you?

MS. SWANSON: Object to form.

THE WITNESS: I would agree that some

abortions, regardless of gestational duration, must take place in a hospital.

Q. (Mr. Boyle) You would agree that anything beyond moderate sedation -- I think we've discussed it. But anything beyond moderate sedation anesthesia level for a surgical abortion must happen in a hospital, not at a PPSAT clinic, right?

MS. SWANSON: Object to form.

THE WITNESS: No, I would not agree to that. Deep sedation can be offered in an outpatient setting if you have the right equipment and staff. PPSAT does not have the staff to perform deep sedation in our outpatient clinics, but that doesn't preclude the safety of performing it in a clinic that has that staff.

Q. (Mr. Boyle) If a patient comes to PPSAT and has an ultrasound, and it's an ultrasound of unknown -- pregnancy of unknown location, do you charge for an additional -- does PPSAT charge for an additional ultrasound if that patient gets an additional ultrasound?

MS. SWANSON: Object to form.

THE WITNESS: Do you mean that if the patient had an ultrasound at an outside location that showed a pregnancy of an unknown location, and then we

performed an ultrasound, would we charge the patient for the ultrasound we performed?

Q. (Mr. Boyle) I didn't mean that, but do you?

A. If we perform an ultrasound, yes, we charge them for ---

Q. And if ---

A. --- the ultrasound performed.

Q. I'm sorry. If you come up with an ultrasound of pregnancy of unknown location and you take another one at PPSAT, do you charge for the second one also?

A. We do not routinely charge for repeat ultrasounds that we feel are clinically necessary, no.

Q. So if you charge for an ultrasound and the patient gets a second or even a third, you don't charge for the second or the third. Is that correct?

A. It is my understanding that we do not routinely charge for repeat ultrasounds that we deem clinically necessary.

Q. Have you ever had a situation where you had a patient with ultrasound finding of pregnancy of unknown location, you gave that patient chemical abortion drugs and then later, you determined that that patient had an ectopic pregnancy?

A. Yes, that has occurred.

Q. Did you give that patient a refund for the

unnecessary procedure that you performed?

MS. SWANSON: Object to form.

THE WITNESS: The patient is charged for the services they receive on the day they receive them, so the patient paid for the services they received, which included medications that they took.

Q. (Mr. Boyle) And you would agree that in that circumstance, the medications that the patient paid for were unnecessary, right?

MS. SWANSON: Object to form.

THE WITNESS: At the time that the medications were given, we did not know that they were unnecessary, so they were given in good faith.

Q. (Mr. Boyle) Absolutely. But had you waited, eventually you were able to determine that that particular patient had an ectopic pregnancy, right?

A. If it had been the patient's preference to wait, we certainly could have waited and not done the medication abortion yet.

Q. Well, you also could have just waited because you don't know where the pregnancy is, regardless of the patient's preference, right?

MS. SWANSON: Object to ---

Q. (Mr. Boyle) That's at least an option?

MS. SWANSON: Object to form.

THE WITNESS: We provide the patient with their options and let them choose. So a patient who is taking medication abortion in the setting of pregnancy of unknown location is aware and informed that they may not have an intrauterine pregnancy, and that if they have an ectopic pregnancy, this medication will not be sufficient to treat that condition.

And then the patient chooses that option, or they choose the other option, such as a diagnostic suction, or to wait while determining the location of the pregnancy.

Q. (Mr. Boyle) You're talking about the evidence-based studies that support your proposition that Planned Parenthood should be able to give chemical abortion drugs simultaneously with a patient with an ultrasound findings of pregnancy of unknown location. Did you consider the Goldberg study?

A. I believe I did look at the Goldberg study, but I'd want to see it to be sure.

Q. Okay. Copy for you.

MS. SWANSON: Thank you.

THE WITNESS: Thank you.

Q. (Mr. Boyle) And take your time, take a look at it, and when you're ready, I'll ask you some questions, please.

A. I see the study.

Q. Okay. Now that you've reviewed that document, is that what you were talking about, with the Goldberg study from 2022, that supports your position that PPSAT should be able to give chemical abortion drugs simultaneously with a ultrasound finding of pregnancy of unknown location?

A. This is one of the studies. I believe I cited two studies on providing medication abortion concurrent with pregnancy of unknown location.

Q. Did you also cite the Boraas study from Minnesota? Do you recall if -- if that were her study? I believe Upadhyay, and I'm terrible with names, I apologize, Upadyay, Upadie (sic), I'm saying that wrong, I know by the look on your face, but that lady who is in San Francisco that does a lot of research. Did you consider that report also?

MS. SWANSON: Object to form.

THE WITNESS: Without seeing the actual document ---

MR. BOYLE: Conceded.

THE WITNESS: --- I'm not comfortable confirming that this is the study.

Q. (Mr. Boyle) Okay.

A. There was a second study that I did cite.

Q. Okay. Well, if it's that one, then that one was published in 2023, and this Goldberg study was published in 2022, right?

MS. SWANSON: Object to form.

THE WITNESS: I can see that this study was published in 2022.

Q. (Mr. Boyle) Are you aware of any other studies from prior to 2022 that would support PPSAT's position on this?

A. I do not have knowledge of all of the full literature on this topic.

Q. When you look at this study, it's a retrospective cohort study of medical records from Massachusetts Planned Parenthood related to giving chemical abortion drugs to a patient with a pregnancy of unknown location. And I was wrong on the dates. It was from 2014 to 2019. Is that correct?

A. That is what I understand this study to be.

Q. Okay. And if you turn to Page Number 779, the second to last page, please. It's -- yeah. And you look on the left-hand column, there's a paragraph that starts with, "Additionally". Do you see that?

A. On the left-hand column, a ---

Q. I'm sorry.

A. --- paragraph ---

Q. Right. Right.
A. --- that starts ---
Q. Right.
A. --- with, "Additionally"?
Q. Right.
A. Yes, on the right-hand column, I do.
Q. Okay. And I'm going to read that and then ask you a question. Quote, "Additionally, some patients who present with undesired pregnancies of unknown location may never require an abortion.

"We found that 18 percent of patients in the delay for diagnosis group were eventually diagnosed with early pregnancy loss, and eight percent with ectopic pregnancy. Thus, collectively, 26 percent did not require abortion," end quote.

Did I read that correctly?
A. You did correctly read that.
Q. And if you extrapolate that, that would suggest that possibly a quarter of the patients that you are treating with pregnancies of unknown location with chemical abortion drugs, one out of four of them don't actually need those drugs, do they?

MS. SWANSON: Object to form.

THE WITNESS: In my clinical experience, and in my education of patients, I discuss with them

that they may be having a miscarriage, as I mentioned, or they may have an ectopic pregnancy, neither of which would be treated by the medications we use.

And in my clinical experience, my patients are exceedingly anxious to complete their abortion, and those who choose the option of medication abortion in the setting of pregnancy of unknown location, are doing so aware of that and wanting to take the chance that this might actually end their pregnancy, rather than delay their treatment and thus delay their ability to end their pregnancy, especially in the setting of bans.

Q. (Mr. Boyle) And I appreciate all of that and understand your position. I believe my question is a little bit more specific than that.

Doesn't this research support a conclusion that up to a quarter, one out of four of those patients who you are giving chemical abortion drugs to when you have a pregnancy of unknown location, if you just waited until you either ruled it in or ruled it out, they wouldn't have needed those medications, right?

MS. SWANSON: Object to form.

THE WITNESS: I believe that this data show that in this study, a quarter of the patients may not have needed the medication and that every patient should have the right to make the decision that is

right for them once they have the medical information.

Q. (Mr. Boyle) Well, I only bring up this study, because you said you relied on it to support your position of giving the chemical abortion drugs to a patient with a pregnancy of unknown location on ultrasound, right?

A. Correct.

Q. And part of this also says that maybe up to 25 percent of them don't need that, right?

A. Which is why patients are informed of the differential diagnosis before they make the decision that is right for them.

Q. There's a risk associated with giving a patient chemical abortion drugs every time they get it, even if they are indicated and needed, right?

MS. SWANSON: Object to form.

THE WITNESS: Every treatment and every decision to not treat carries a risk, because the decision to not treat is also a decision.

Q. (Mr. Boyle) Eight percent of the people he studied, Goldberg and his group studied, who had ectopic pregnancies and waited, they didn't get the chemical abortion drugs. And if they had gotten them, it actually would have been contraindicated for them under that circumstance, right?

MS. SWANSON: Object to form.

THE WITNESS: First of all, I believe Dr. Goldberg uses she pronouns. Second, the 8 percent of ---

MR. BOYLE: I'm sorry. I apologize. I had never looked at the first name, and that was very sexist of me. I apologize.

THE WITNESS: So the medication abortion in 8 percent of patients who had an ectopic pregnancy, the medication abortion would not treat that ectopic pregnancy. Medication abortion is contraindicated when you know you have an ectopic pregnancy, but it does not cause harm itself to an ectopic pregnancy, nor does it treat an ectopic pregnancy.

Q. (Mr. Boyle) But there are some associated risks with the mere fact of taking mifoprex (sic) and misoprostol, right?

MS. SWANSON: Object to form.

THE WITNESS: Any medication that is taken does carry potential risks, including mifepristone and misoprostol.

Q. (Mr. Boyle) You would agree that there's at least some consensus today that a patient with a pregnancy of unknown location should not be given chemical abortion drugs until serial ultrasounds are

taken to either rule in ectopic pregnancy or rule it out, wouldn't you?

MS. SWANSON: Object to form.

THE WITNESS: No.

Q. (Mr. Boyle) You agree there's no ACOG Bulletin that says that it's okay to give a patient with a pregnancy of unknown location chemical medication -- or chemical abortion drugs, right?

MS. SWANSON: Object to form.

THE WITNESS: I am not familiar with the contents of every ACOG Bulletin.

Q. (Mr. Boyle) I'm just going to be willing to bet that if there was an ACOG that supported that position, you would have included it in your Declaration, right?

MS. SWANSON: Object to form.

THE WITNESS: I did not read all of the ACOG Bulletins in my preparation for this Declaration.

Q. (Mr. Boyle) Fair enough. And if there had been one that said that was okay, or the common practice, don't you think you would have included it?

MS. SWANSON: Object to form.

THE WITNESS: That's speculation. I'm not familiar with all of the ACOG Bulletins.

Q. (Mr. Boyle) Okay. So if you turn to Page

780, the last page of the Goldberg study.

A. 780?

Q. 7-8-0. This one.

A. Yes.

Q. Okay. If you look at the last sentence, it says, quote, "Given that both management strategies are reasonably safe and effective, and that each carries benefits and risks, our data informed shared decision making and enabled choices heavily weighted toward patient priorities and preferences," end quote.

Do you see that?

A. I see that statement.

Q. And that means that Goldberg, she may have found that it's okay to give chemical abortion medications to a patient with pregnancy of an unknown location, but she also found that it's also -- it's also reasonable and safe to wait, didn't she?

A. What I read -- understand that statement to say is that patients should be informed of their options and make a choice that works best for their preferences and their personal medical condition.

Q. And the choice is between getting chemical abortion drugs with a pregnancy of unknown location ultrasound finding before you confirm intrauterine or waiting and confirming intrauterine or ruling in

ectopic, right? Those are the two choices there, one or the other?

MS. SWANSON: Object to form.

THE WITNESS: There is -- there are other choices. She references in this sentence those two choices.

Q. (Mr. Boyle) Yes. I'm -- that's what I'm talking about. I'm sorry. This sentence, she references go ahead and taking the chemical abortion drug or waiting and ruling in or out ectopic pregnancy, right?

MS. SWANSON: Object ---

THE WITNESS: I'd like to reread the paragraph before I answer that question.

Q. (Mr. Boyle) Help yourself. Please do.

(Witness examines document)

A. Actually, I'm going to go back further.

All right. Can you repeat your question?

Q. (Mr. Boyle) Yes. On Page 780, the end of the study, she determines that the option that PPSAT is promoting the giving of chemical abortion drugs while a patient has an ultrasound finding of pregnancy of unknown location, option one, versus option two, waiting and having repeat tests to actually rule in or rule out ectopic pregnancy with ultrasound. She found

that both of them carry risks and benefits, and they're reasonable safe, didn't she?

A. To be clear, Planned Parenthood South Atlantic offers both options to patients with pregnancy of an unknown location. We don't only offer medication abortion in the setting of pregnancy of unknown location.

We offer the patient both options so that they can, as she says, use shared decision making and choose the choice that makes the most sense for them.

Q. She says both options are reasonably safe and effective, right?

A. Correct.

Q. Which would mean that the option in the law is reasonably safe and effective, right?

MS. SWANSON: Object to form.

THE WITNESS: It is an option that is reasonably safe and effective, but significantly limits the patient and does not provide them with an equally safe and effective option.

Q. (Mr. Boyle) Okay.

MR. BOYLE: I don't think I have any further questions. And I thank you very much for your time. Other folks may, so you're not off the hook yet, but close.

THE WITNESS: I'd actually love a break if I can ---

MR. BOYLE: Suits me.

MS. SWANSON: Yeah. If we could -- could we take maybe a ---

THE WITNESS: Twenty?

MS. SWANSON: --- 20-minute break? Yeah.

THE COURT REPORTER: It's 2:20 now.

MS. SWANSON: Oh. It's 2:20 now?

THE COURT REPORTER: Uh-huh.

MS. SWANSON: Okay. Then let's take 15 minutes, come back at 2:35, if that's okay?

MR. BOYLE: Don't trip -- the unplug ---

THE WITNESS: I know. I was actually, this time, for the first time ---

THE VIDEOGRAPHER: Off record.

(Brief recess: 2:20 p.m. to 2:41 p.m.)

THE VIDEOGRAPHER: On record, 2:41.

MS. SWANSON: All right. I have just a few follow-up questions for Dr. Farris.

EXAMINATION

BY MS. SWANSON:

Q. So Dr. Farris, we've been talking about the Goldberg study that you cited in your Declaration. Do

you have that in front of you?

A. Yes, I do.

Q. I'd like you to look at Page 780 of the Goldberg study.

A. I see that.

Q. And this is the final paragraph that we were just discussing before the break. Do you see that paragraph?

A. I do.

Q. I'm going to read a section of that paragraph. "There is no reason to mandate that these patients with pregnancies of unknown location delay initiating abortion to first obtain a definitive diagnosis." Do you agree with that statement?

A. I do.

Q. I'd now like to look at the ACOG Bulletin that we were discussing earlier. This is ACOG Bulletin Number 193.

A. I have that.

Q. I'm on Page E-92.

A. Yes.

Q. Under Clinical Considerations and Recommendations, subpart How is an Ectopic Pregnancy Diagnosed, I'm going to read the first sentence of that paragraph. "The minimum diagnostic evaluation of a

suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy."

Dr. Farris, is a patient with a pregnancy of unknown location, who has been determined low risk of ectopic, a suspected -- a patient with a suspected ectopic pregnancy?

A. No, I would not consider them as having a suspected ectopic pregnancy.

Q. So for patients who have obtained an ultrasound and been determined to have a pregnancy of unknown location, are those patients with a suspected ectopic pregnancy?

A. No, I would not consider that they are suspected to have an ectopic pregnancy.

Q. Earlier, you testified that at that point, after an ultrasound has been done and they have been determined to have a pregnancy of unknown location, ectopic pregnancy might be on their differential diagnosis, right?

A. That is correct.

Q. What do you do to continue to exclude ectopic pregnancy in your differential diagnosis from that point?

A. We would do serial ultrasounds and/or serial blood tests for beta HCG.

Q. Do you do any additional screening through questions about the patient's medical history?

A. We very carefully screen the patient, both in their medical history, their pregnancy history, the history of their last menstrual period and other risk factors that might put them at higher risk for ectopic pregnancy.

Q. And based on that screening, that ectopic pregnancy screening, might somebody from the pregnancy of unknown location category, move to a patient with a suspected ectopic pregnancy?

A. Yes, those screening questions could make me suspect ectopic pregnancy.

Q. And for those patients, would you provide medication abortion using the pregnancy of unknown location protocol?

A. No, I would not.

Q. So for patients who have been screened for ectopic pregnancy, patients with pregnancies of unknown location who have been screened for ectopic pregnancy and determined to be low risk for ectopic pregnancy, what happens next in your counseling of those patients?

A. We counsel the patients that they essentially have three options. They can undergo what we call a diagnostic suction, which is performing a procedural

abortion and looking to see if we see pregnancy tissue removed from the uterus.

They can undergo a medication abortion while we concurrently evaluate for the presence of ectopic pregnancy through serial ultrasounds and serial blood tests. Or they can choose to wait to initiate abortion care and only go through the concurrent screening process of serial ultrasounds and/or blood tests.

Q. What additional counseling do you provide to those patients who do choose to have a medication abortion with a pregnancy of unknown location?

A. We speak to them at length and very carefully about not only the normal symptoms they should expect with mifepristone and misoprostol, but also any abnormal symptoms that might occur with ectopic pregnancy.

We make sure they understand how critical it is that they seek out care, either by calling us or going to a local emergency department should they experience those symptoms.

And we also inform them that we will be closely following up with them about their lab results, and that it's very important that they answer the phone when we call so we can check in on how they're doing.

Q. Shifting gears a bit. Even if it's true that

abortion becomes riskier as pregnancy advances, why does a hospitalization requirement starting at 12 weeks of pregnancy undermine patient safety?

A. For two reasons. First of all, we know that outpatient abortion is safe well beyond 12 weeks. We have plenty of data for that. But the other thing we know is that when we require abortions to be -- take place in a hospital, that usually delays their care. So by delaying their care, we are actually increasing their incremental risk of those complications.

Q. You testified that you consider abortions after 14 weeks zero days of pregnancy to be D&Es, correct?

A. That's correct.

Q. Do you ever provide an abortion, a procedural abortion, after 14 weeks without the need for additional instrumentation on top of the aspiration using a suction cannula?

A. Yes. Very frequently.

Q. Shifting back to medication abortion for a moment. What does it mean for mifepristone to be contraindicated for ectopic pregnancy?

A. That means that if you know a patient has an ectopic pregnancy, or if you strongly suspect a patient has an ectopic pregnancy, it is not appropriate to give

mifepristone and misoprostol, because they will not treat that condition.

Q. In what capacity do you understand yourself to be testifying here today?

A. I am here testifying as an expert on abortion care, and specifically also as an expert on the clinical care provided by Planned Parenthood South Atlantic.

Q. You testified that it's not possible to know in advance whether a patient will experience a complication from any given procedure. But is it possible to know in advance whether some patients have specific medical characteristics that would make them candidates for obtaining an abortion at a hospital rather than in the outpatient setting?

A. Yes, it is possible to screen patients for likelihood of complications. And at PPSAT, we screen all of our patients for different conditions that make it more likely. If we identify a patient that we feel is highly likely to experience a complication, we will refer them rather than performing the abortion in the outpatient setting.

Q. Why haven't you pursued hospital admitting privileges to provide abortion in North Carolina?

A. Hospital admitting privileges are a business

agreement, traditionally between an outside or a community provider who then does a lot of business with the hospital or has a lot of patients who need to be in the hospital.

It's my experience that very, very, very few of the patients that I treat need to be seen in a hospital, so it doesn't make sense for me to enter into that business agreement.

MS. SWANSON: Thank you, Dr. Farris. I'm going to pause just for a few moments to confirm I have no further questions.

A couple more.

Q. (Ms. Swanson) Approximately what percentage of patients in North Carolina use insurance to pay for their abortions?

A. I don't know exactly, but I believe it is less than 5 percent.

MS. SWANSON: I have no further questions for you, Dr. Farris.

THE WITNESS: I'm sorry, my phone's buzzing.

MR. BOYLE: Just one brief follow-up there.

FURTHER EXAMINATION

BY MR. BOYLE:

Q. Dr. Farris, you said that the chemical med -- chemical abortion drugs are contraindicated if you strongly suspect there is an ectopic pregnancy or if you confirm that there is ectopic pregnancy. But are you aware that the FDA regulation label itself actually says, "if you confirm or suspect there is an ectopic pregnancy"?

MS. SWANSON: Object ---

THE WITNESS: I wouldn't ---

MS. SWANSON: Object to form.

THE WITNESS: I'd need you to show me the label to be able to say what the label says.

Q. (Mr. Boyle) If it says what I'm suggesting, then you agree that's different than "strongly suspect," right?

MS. SWANSON: Object to form.

THE WITNESS: I think that there are varying degrees of suspicion. So you can have very low suspicion, where something is in your differential diagnosis, or you can have a very high suspicion, and there is a spectrum. I think clinicians should be using their judgment to determine where on that spectrum a patient's risk falls.

Q. (Mr. Boyle) And I'm just asking though, specifically, it's different -- you would agree there's

a difference if the FDA labels says, "Suspect ectopic pregnancy," as opposed to what you just said, which was "strong suspicion," right? There's a difference?

MS. SWANSON: Object to form.

THE WITNESS: I agree that there is a difference between the phrase "suspect" and the phrase "strongly suspect."

MR. BOYLE: Okay. No further questions. Thank you.

THE COURT REPORTER: Follow-up?

MS. SWANSON: No more for me.

THE COURT REPORTER: Okay.

THE VIDEOGRAPHER: Off record, 2:51. That concludes the deposition.

(Brief recess: 2:51 p.m. to 2:52 p.m.)

THE VIDEOGRAPHER: On record, 2:52.

THE COURT REPORTER: Is there any other counsel appearing via Zoom that would like to question the witness?

MR. WILLIAMS: No, thank you.

MR. WOOD: This is Michael Wood. No questions by me.

THE COURT REPORTER: Thank you.

MS. NARASIMHAN: No questions for Sripriya Narasimhan.

THE COURT REPORTER: Okay. All right. Thank you, Counselors. This concludes our deposition.

THE VIDEOGRAPHER: This concludes the deposition. The time is 2:52.

WHEREUPON, at 2:52 o'clock p.m., the deposition was adjourned.

CERTIFICATION

I, Laura Baker, Notary Public in and for the County of Iredell, State of North Carolina at Large, do hereby certify:

That said witness was sworn by me to state the truth, the whole truth, and nothing but the truth, in said cause and appeared before me at the time and place herein aforementioned and the foregoing consecutively numbered pages are a complete and accurate record of all the testimony given by said witness;

That the undersigned is not of kin, nor in anywise associated with any of the parties to said cause of action, nor their counsel, and not interested in the event(s) thereof.

Reading and signing of the testimony was requested.

IN WITNESS WHEREOF, I have hereunto set my hand this 6th day of September, 2023.

Laura Baker

CHAPLIN & ASSOCIATES

Notary No. 202029500095

WITNESS CERTIFICATION

I, KATHERINE A. FARRIS, MD, do hereby certify,

That I have read and examined the contents of the foregoing pages of record of testimony as given by me at the times and place herein aforementioned;

And that to the best of my knowledge and belief, the foregoing pages are a complete and accurate record of all the testimony given by me at said time, except as noted on the attached here (Addendum A).

I have ____ / have not ____ made changes/corrections to be attached.

_____

(WITNESS SIGNATURE)

I, _____, Notary Public for the County of _____, State of _____, do hereby certify:

That the herein-above named personally appeared before me this the _____ day of _____, 20____;

And that I personally witnessed the execution of this document for the intents and purposes herein above described.

_____

NOTARY PUBLIC

My Commission Expires: (SEAL)

ADDENDUM A

Upon the reading and examination of my testimony as herein transcribed, I note the following changes and/or corrections with accompanying reason(s) for said change/correction:

Page	Line	Is Amended to Read